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S. Hrg. 101-845

Senate Hearing

Before the Committee on Appropriations

Community Health Center/ National Health Service Corps

Fiscal Year 1991

101*st* CONGRESS, SECOND SESSION

SPECIAL HEARING

S181-37

S. HRG. 101-845

COMMUNITY HEALTH CENTER/ NATIONAL HEALTH SERVICE CORPS

HEARING

BEFORE A

SUBCOMMITTEE OF THE

COMMITTEE ON APPROPRIATIONS

UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

SPECIAL HEARING

Printed for the use of the Committee on Appropriations

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COMMUNITY HEALTH CENTER/NATIONAL HEALTH SERVICE CORPS

SATURDAY, JUNE 16, 1990

U.S. SENATE,
SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES,
COMMITTEE ON APPROPRIATIONS,
Waterloo, IA.

The subcommittee met at 3 p.m., at the Bell Building, Waterloo, IA, Hon. Tom Harkin (chairman) presiding.

Present: Senator Harkin.

Also present: Senator Daschle.

NONDEPARTMENTAL WITNESSES

STATEMENTS OF:

DR. DON WEAVER, DIRECTOR, NATIONAL HEALTH SERVICE CORPS

DR. RON ECKHOFF, ACTING DIRECTOR, IOWA DEPARTMENT OF PUBLIC HEALTH

ROGER TRACY, DIRECTOR, OFFICE OF COMMUNITY BASED PROGRAMS, UNIVERSITY OF IOWA, COLLEGE OF MEDICINE

OPENING REMARKS OF SENATOR HARKIN

Senator HARKIN. Ron, thank you very much. And first of all, let me apologize on behalf of both Senator Daschle and myself. We were obviously going to fly up here today from Des Moines, but we had to drive; and the weather is really awful. I mean if you think it is bad here, you should see what it is like in Des Moines. There is really some bad weather, so it just took us a long time to get here. We apologize for that delay.

I want to thank you all for coming, and I especially want to thank Senator Daschle for his willingness to join us here today. As you know, Senator Daschle is a Senator from South Dakota. We have served together in the House of Representatives and now serve together in the Senate.

I have a part to play in health care, in that I chair the Labor, Health and Human Services Subcommittee that appropriates money for a lot of our programs, like the National Health Service Corps, community health centers, things like that.

Senator Daschle has an extremely important position on the Senate Finance Committee which develops health care legislation in Congress dealing with Medicare and Medicaid, and everything else; and he serves on both of the health subcommittees of the Fi-

nance Committee. So that is why I wanted Senator Daschle to join us, and I am really pleased that he is here with us today.

I guess I am supposed to say the Subcommittee on Labor, Health and Human Services, Education will come to order, retroactively to what I just said.

I am especially grateful to, again, to Ron Kemp, the executive director of the Peoples Community Health Clinic, for lending us the clinic today; and to the Iowa/Nebraska Primary Health Association for their help.

I want to thank Dr. Ron Eckhoff of the Iowa Department of Public Health for joining us and proud that this hearing brings together State and Federal officials concerned with health care in Iowa's communities.

Perhaps the most important witnesses today are the dedicated health professionals who serve Iowa's three community health centers and the people who can use their services. I am delighted that they could be here.

We are here today to look at the health care services available in our State of Iowa, especially focusing on the underserved areas of the State. These areas suffer from shortages of physicians, nurses, and other health care providers. In some cases, particularly in the smaller communities, there just simply are no providers.

A big part of the problem comes down to inequitable Medicare rates. There is no escaping the fact that paying hospitals and doctors less for work provided in rural areas than for the same work in urban areas, or paying substantially less to Iowa health providers than those in New York or California, is contributing to the health care crisis in many rural areas. I am committed to changing that, and I know my colleague, Senator Daschle, is also. We are going to keep working for equity.

But Medicare is only a part of the picture. For those who are uninsured or underinsured, affordable primary health care services are critical. That is where Federal support for community health centers, like Peoples Health Clinic here in Waterloo, comes in.

Community health centers deliver quality, cost-effective primary health care in underserved and rural urban areas. Their presence can greatly increase access to care.

NATIONAL HEALTH SERVICE CORPS

National Health Service Corps fills a critical gap. It places physicians and nurses and other health professionals in designated health manpower shortage areas.

Iowa currently has three community centers; one in Waterloo, one in Davenport, one in Des Moines. These health centers receive $2.5 million of Federal grant funding through my appropriations subcommittee, and they serve almost 35,000 mostly indigent people each year. In many cases the medical staff that serves in these health centers are National Health Service Corps doctors, another Federal program funded under my subcommittee.

Iowa has 26 health manpower shortage areas, which include an estimated 220,000 people that are medically underserved. These health manpower shortage areas are areas which have fewer than one doctor for every 3,500 people. To remove the designation from

these 26 areas would require the placement of another 28 primary care physicians. The term of service for seven of these doctors expires this year, in 1990.

We need to increase and not reduce the number of doctors in Iowa, and this hearing will give us a chance to look at the options that we have.

OPENING REMARKS OF SENATOR DASCHLE

Those conclude my opening remarks. I would ask Senator Daschle if he has any opening remarks he would like to make from his vantage point, being on the Finance Committee.

Senator DASCHLE. Well, Tom, let me thank you for the opportunity to participate in this hearing this afternoon.

Senator Bob Kerrey and I have just concluded a series of hearings in Nebraska and South Dakota dealing with exactly the same area. The Senate Finance Committee in the next couple of years expects to take a number of different legislative vehicles under consideration to see if we cannot more effectively address the problems of health care delivery shortage in rural America today.

In South Dakota two-thirds of our State is a primary-care shortage area. In South Dakota we currently have 40 doctor vacancies and 220 vacancies for nurses. We continue to find that access becomes an increasingly acute problem as we address health care from a rural point of view. As Senator Harkin so correctly stated, one of the biggest reasons why rural health care is having the difficulty it is is the inequitable reimbursement rate that exists between urban and rural areas, and the differences that both hospitals and doctors must experience in being reimbursed through the Federal Government. That is wrong, and it has to change.

We also believe that recruitment of doctors has become more of a problem in recent years, in large measure because of the dramatic reduction in the availability of doctors through the National Health Service Corps.

We have gone from 2,200 doctors in the Corps in 1978 to 200 last year, and the program is expected to zero out in the next 2 years unless we make some fundamental changes.

I also believe that there ought to be a nurse set-aside for the National Health Service Corps to provide greater access to doctors and to nurses for rural shortage areas.

So we do have a series of challenges in store, and hearings like this help us better understand these issues and provide a vehicle with which to communicate more effectively with those who are in the trenches providing the kind of health care that you all do here in Waterloo.

So with that, I am anxious to hear the witnesses, and I am sure it will be a very successful and productive hearing.

INTRODUCTION OF PANEL

Senator HARKIN. Senator Daschle, I thank you very much. I am pleased to introduce our first panel. We have with us today Dr. Don Weaver, Director of the National Health Service Corps. I am really glad you could take the time to come here from Washington

to give us up-to-date data on where the health manpower shortage areas are and where the medically underserved areas are in Iowa.

I want to learn from Dr. Weaver and the other witnesses the areas in Iowa which they believe could best be served by additional community health centers and by placement of additional National Health Service Corps doctors.

Joining Dr. Weaver is Dr. Ron Eckhoff, who is the acting director of the Iowa Department of Public Health. He is here today from Des Moines.

And finally, Roger Tracy joins us from the University of Iowa, College of Medicine. Mr. Tracy is an expert in Iowa health manpower needs. He will be able to tell us about the trends he sees in Iowa's need for physicians and the current physician supply to our State, especially in the smaller communities.

Again, I welcome all of you here, and I'm honored and pleased you could be here.

I must tell you, since we had a long drive up here, I was able to read everyone's statement before I got here; and in the interest of time, I would appreciate it if you could sort of summarize your statement and hit the highlights. And like I always tell witnesses when I chair a hearing, what are the one, two, or three things that you would like to stick in our memory banks when we walk out of here today? That is what we want.

STATEMENT OF DON WEAVER

So welcome, and we will start off first with Dr. Don Weaver, Director of the National Health Service Corps, of Rockville, MD. Dr. Weaver?

Dr. WEAVER. Thank you. Thank you, Senator Harkin, Senator Daschle. I will cut my remarks short. You actually did not have the benefit of a copy of my remarks, because they were sort of developed in transit; but I will certainly send them to you and try to hit the highlights of what I wish to share with you.

I am here representing the Health Resources and Services Administration today, which is HRSA. We always use our name because people always tend to know NIH and CDC and other agencies a little better than they do ours, so we always take a chance to talk about ours, and to specifically talk about the community and migrant health center programs in the National Health Service Corps, which are programs that were initiated and continue to be utilized to help improve access to primary care services to underserved people.

I think if I had to briefly summarize the short messages I hope that you and others would take back it is that the Community Health Center Program is a grant program targeted to medically underserved areas where there is a need for financial resources to develop or enhance the system of care, as compared with the National Health Service Corps, which is a human resource program which is targeted to help manpower shortage areas, where you need health personnel to enhance or develop a system of care.

There are many areas which are both medically underserved and health manpower shortage areas, which need both people and dollars. And so there is a little bit of difference in the way they are—

that the determinations are put together; but I think the bottom line is medically underserved areas are used to designate where grant dollars or dollars are needed to supplement local resources to develop the system of care or improve it, and the National Health Service Corps is a human resource program which uses health manpower shortage areas as a designation criterion.

I mention that because I think at times it is confusing for people. And I think it is the top map of the two—I think I have got that—that shows the medically underserved areas in the State of Iowa. The medically underserved areas are based on the criteria that were basically put together based on four areas. One is the number of primary care physicians to population—that is where there is certainly some similarity to HMSA's—the infant mortality rate, the percent of the population with families below the poverty level, and the percent of area population which is 65 or older.

And what you could do is look at the top map and see, indeed, using those criteria from a national perspective, that is where you get the medically underserved areas in the State of Iowa.

With respect to dollars available for expansion of health centers under the current President's budget—and I think that is something I know people are interested in—the President's budget for fiscal year 1991 calls for $438 million for community health centers, $48 million for migrant health centers; and an additional $36 million to target the special population with a focus on infant mortality, and $13 million targeted for special populations with a focus on increases to systems of care providing services for people with AIDS.

While there is an increase, as you look at that, over last year's budget of about $11 million, it is anticipated that the vast majority of that increase would go toward retention and recruitment efforts in existing community and migrant health centers.

There is also part of the President's budget, some $35 million, to support the provision of health and social services in underserved neighborhoods, especially public housing units, which will be targeted to community-based organizations as well, which health centers could be applicants for as they look at possible expansion of their activities.

Let me shift gears, if I may, very briefly to the National Health Service Corps. That is the one I am most familiar with and am always pleased to talk about. It is a people program. We have targeted the people program.

There have been over 13,000 people that have received scholarships through the National Health Service Corps. The vast majority of them serve, I might add. We always hear about the small number of people who defaulted on their obligation; but indeed, over 83 percent of the individuals who receive scholarships from the National Health Service Corps have served.

The largest numbers of scholars were placed in—available for placement in 1985, when we had roughly 1,600 people to place. To put that in perspective, we had 120 people to place this current year; 74 scholars will be available for service next year, and the following year there will be less than 50 people to place.

I think it is fair to say that with the studies in the 1980's, including the GMENAC study, the Graduate Medical Education National Advisory Council, with the prediction that there be an impending oversupply of physicians, the buzz word was diffusion. People felt that diffusion would, indeed, take care of the physician needs in rural America, as well as the urban inner cities.

I think it is fair to say that it is well established now that clearly this is not the case. Whether there is going to be oversupply or not is still up for debate, at least during the debates of the council on graduate medical education.

That same council also indicated that, indeed, from a medical perspective, physicians are not going into that primary care specialty in the numbers that people would have hoped to meet primary care needs; and certainly this diffusion concept has not worked, as we have needs continuing in rural America and in the urban inner cities.

To give you an idea, nationally there are a little over 1,930 primary care health manpower shortage areas which would require roughly 4,100 primary care physicians to fully meet those needs. When you add to those numbers 691 psychiatric health manpower shortage areas, which would take a little over 1,800 psychiatrists or psychiatric health professionals to deal with, and 973 dental health manpower shortage areas, which would require about 1,750 dentists to fill those needs, indeed, the numbers for underserved populations that need providers are quite large.

Our current field strength, when you count everybody, when you count Federal field employees, people who are under some sort of scholarship obligation who we have helped recruit through Federal loan repayment or worked with States for State loan repayment, is somewhere around 1,800.

We anticipate that approximately 900 scholars will be completing their obligation this year. The studies on how many of those individuals will be staying vary. The more optimistic ones are around 30 to 35 percent. Some of them are markedly less than that. And then you compare those potential losses with 120 scholars we have for placement this year, approximately 75 Federal loan repayment contracts we were able to do, and an estimated 100 that we will do in about seven States in which we have combined Federal/State loan repayment activities.

Suffice it to say the focus for the Corps is on retention and recruitment. I think one of the things that happened when the Corps had such large numbers to place, we became a placement service. We had large numbers and needed to worry about where these individuals would go.

I think now what people realize is with smaller numbers, keeping people that are currently out there is equally as important as finding new people to go out there. In fact, indeed, more cost effective.

The bottom map here is a map that shows the health manpower shortage areas in the State of Iowa. Roughly you can say that any person, agency, or community can request designation of either an area, of a population group, or a facility. The major criterion for a

health-manpower shortage area is a rough physician-to-population ratio of 1 to 3,500 or greater, although there are exceptions made for populations of 1 to 3,000 if there is an unusually high need, as evidenced by high poverty levels, a high infant mortality rate, or increased waiting times and visit rates in adjacent areas.

Suffice it to say—and maybe it states the obvious—obviously a health manpower shortage area needs to be a rational service area as well; and when you look at these service areas, you also take into consideration contiguous areas to make sure that, indeed, a HMSA that might look extremely needy does not have something right next door that is 1 mile away, because it is in a different county makes a difference. So that is how we come up with those particular designations.

I think it is important to realize that copies of the request for designation are shared and actually developed in conjunction with the State health planning agencies in cooperative agreements, the State medical or dental society, the Governor's office, and certainly the case in the State of Iowa, the University of Iowa, for review and comment. Because far be it from us to say in Washington we have the best idea or impression of where the needs in Iowa are—in your case, Mr. Daschle, in South Dakota are—so we work very closely with those State entities.

The HMSA's in Iowa total 26 primary care HMSA's; 7 of those are whole counties; 17 are partial counties; 2 of them are population groups. And as Senator Harkin mentioned, 28 practitioners—primary care practitioners will be needed to fill those.

Six dental HMSA's. Five are whole counties, one is a population group, and requires 13 dentists to fill those.

There are 12 psychiatric HMSA's in Iowa; 1 of them is a whole county, 2 of those are facilities, 9 of those are partial counties, and would need 29 providers to completely fill those.

I think one important issue that many people are aware of that bears mentioning with respect to health manpower shortage areas is that there are 12 Federal programs that use the designation of health manpower shortage area for part of what they do. In particular, too—I think it would be important—in this State are the Rural Health Clinics Act and the Medicare reimbursement that was mentioned, and I believe it is 5 percent and will be targeted to increase to 10 percent at some time in the next year or so.

Important to remember, because HMSA's are more than just providing National Health Service Corps assignees. They have a whole lot of other things that go along with that. Currently there are 12 National Health Service Corps assignees in the State of Iowa—some of them are here today, and I had a chance to chat with them, which is always fun for me to do, to meet the reality of what the papers indicate in Washington—7 family physicians, 3 psychiatrists, and 2 interns. Now, that is the good news, if we talk about the optimistic side. Seven of those are completing their obligations either this month or next month in this year; and I believe the number, now, is two of them will be staying in this State.

RECRUITMENT CYCLE

We were successful in a loan repayment match in the 1989-90 recruitment cycle. We are currently—and I think, Roger, you will talk a little bit about this. They are developing a list for the 1991 recruitment cycle in conjunction with not only the University of Iowa, but the Iowa Cooperative agreement, and they have identified—and I hope our numbers match—26 people who we would like to assist in recruiting.

I think the two concluding comments would be we ought to talk about budgets, in terms of the National Health Service Corps. President Bush's budget for the National Health Service Corps is a generous increase. For our field strength program, there will be an approximate $500,000 increase, which helps us support Federal employees in the field and also the support activities, which we feel are very important in maintaining the people that we currently have out in the field.

In addition, there is a $55 million increase in the Scholarship and Loan Repayment Program, going from $9 million to $64 million. That $55 million is from the Secretary's minority health initiative.

Our proposal would be to combine the 55 and 9 and make the entire focus of our Scholarship and Loan Repayment Program on minority and disadvantaged individuals. So I think there is a reason to be optimistic about a revitalized National Health Service Corps in the future.

Our hope for the future for both of these programs, community health centers and the Corps, is to work with State and local health departments, to work with State cooperative agreements and other organizations, to work with State regional primary care associations, to work with State health professions institutions, and with the private sector, to be partners in meeting the needs of underserved Americans. Thank you.

Senator HARKIN. Dr. Weaver, thank you very much. We will go through the panel. I have got a question I want to ask you about the two charts there. Maybe Roger or someone else will be talking about those also.

STATEMENT OF DR. RON ECKHOFF

Next we will turn to Ron Eckhoff, who is acting director of the Iowa Department of Public Health. Again, thank you for driving up here this morning.

Dr. ECKHOFF. Thank you, Senator. Appreciate very much the opportunity to meet here today. I will cut a little bit out of what I was going to say, since you already have it.

Iowa citizens, communities, and policymakers are looking closely at the current status of delivery of primary health care services for all Iowans. Gaps are being identified, accessibility of services is being looked at, options are being discussed, and there is a great deal of activity taking place that bears on this.

Just to touch very briefly on several things, a rural health task force made recommendations to the Governor regarding health care service delivery systems, personnel, and high-risk populations within the past year. Also, a Health Professional Shortage Commit-

tee responded to the Iowa Legislature with a report that addressed the current status and future needs of 18 health professions in the State.

This year for the first time we have a public health service cooperative agreement, and one of the key things in that includes the working group of 16 State departments and health care organization representatives. This group is meeting regularly to address both short- and long-range problems and issues. It is planning a workshop for a number of leaders this fall to address those things in more depth.

Two committees at the State level are health care expansion task force, composed of legislators and selected laypersons; and also a Governor's Blue Ribbon Committee on the Uninsured, and are both working cooperatively in the area of uninsured Iowans. The reports are due out before the next legislative session. There is some data in what I have provided to you, in terms of numbers of uninsured in the State; and I will not go through those numbers.

The Maternal and Child Health Program, which is supported by title V, maternal and child health block grants, is administered by the Iowa Department of Public Health. We have 23 maternal health centers and 25 child health clinics which provide services to nearly all Iowa counties.

Some of the 1990 objectives in this program are to improve access to and provision of comprehensive services to low-income and high-risk pregnant women. We do have a maternity care task force currently working on addressing problems in access to maternity care in Iowa. We have increasing problems in that area. We are working very hard to work very cooperatively with Medicaid, with WIC, and with family planning agencies, to improve perinatal outcomes. Also working with the Medicaid people and WIC and others to increase utilization of EPSDT program.

An Office of Rural Health was established within the Department of Public Health in 1989, and this program is looking at a variety of rural health issues which crosscut many areas. And certainly one of the things we see is that community involvement is a key ingredient. We think, through analysis of the current status of the primary health care delivery system, identification of the needs of the communities and gaps in services, we will be able to develop plans for action.

EMERGENCY MEDICAL SERVICES

Emergency medical services have been strengthened with State funds for training, certification, and equipment in the past 2 to 3 years. We have some special programs, private, public cooperative areas to try to address children who are not eligible for any other health care services.

I will skip over the things I was going to say about the health manpower shortage areas and basically skip over the National Health Service Corps of physicians. I could repeat some of the numbers that have been mentioned, in terms of the decreases there.

Five Iowa hospitals received Federal rural health transition grants in fiscal year 1989. This year 28 grant applications repre-

senting 43 rural hospitals have been submitted to HCFA. Four of these applications came from consortiums of hospitals. So hospitals are clearly working together and see a variety of programs as ways to strengthen the Iowa health care network.

This year for the first time the Iowa Legislature appropriated some funds for a State Physician Loan Repayment Program, and for 2 years now we have had a Nursing Loan Repayment Program. The State is about to submit an application to the Public Health Service for the Federal State Loan Repayment Program, asking for matching funds in relation to the State funds.

Now, one of the things I understand is the current House version of the reauthorization does not allow the State/Federal matching, whereas the Senate version does allow it, and we would certainly appreciate your continued support to try to see that the Senate version prevails on that so that we will be able to make the most in that area. I was going to say some nice things about the three community health centers we have in the State; but I think they know that, so we will skip over that. But we are very supportive of the community health center concept.

When we look at the State we notice that the western half of the State has 13 of the current health manpower shortage areas, plus two more pending ones; and yet we have no community health clinics in the western half of the State. We note that four of those health manpower shortage areas with a population of over 60,000 people are clustered around Woodbury County. Another four, with a population base of over 30,000, are in and around Pottawattamie County. So it might be feasible to consider the development of a new CHC in that area, or possibly expansion from the Charles Drew Health Center in Omaha, which serves a few Iowans currently.

So we believe additional funds could allow us to either expand or develop new community health centers in the State, and some of the rural hospitals might also be interested in being involved in this area.

In summary, basically we have a substantial number of indigent uninsured Iowans; we have an increasing gap, in terms of availability of primary care physicians and other health service professionals; and we would welcome the opportunity to work with HRSA, with local communities, with health care providers, and others, to explore the development and/or expansion of community health center sites and programs in Iowa.

PREPARED STATEMENT

We think we are developing a strong network of providers, organizations, businesses, government and policy leaders, who are interested in addressing the delivery of primary health care services. I think some of these many fairly recent activities indicate there is a good bit going on. Our capability to respond is increasing, and we think by working together at the State, Federal, and local level, we will be able to achieve positive results. Thank you.

Senator HARKIN. Ron, thank you very much.

[The statement follows:]

STATEMENT OF DR. RON ECKHOFF

PRIMARY HEALTH CARE SERVICE IN IOWA - A STATE PERSPECTIVE

Iowa's citizens, communities and policy-makers are looking closely at the current status of the delivery of primary health care services for all Iowan's. Gaps in the availability of health care personnel, and the accessibility of health services are being identified. Options that would address these gaps are being discussed. A great deal of activity is taking place.

In the past year:

* A Rural Health Task Force made recommendations to the Governor regarding health care service delivery systems, personnel, and high risk populations.

* A Health Professional Shortage Committee responded to the Iowa Legislature with a report that addressed the current status and future needs of eighteen (18) health professions.

* A Public Health Service (PHS) Cooperative Agreement, awarded to Iowa for the first time this year, includes a "working group" of sixteen (16) state departments and health care organization representatives. This group meets regularly to address both short and long-range problems and issues, and to explore ways to strengthen the health care delivery system in Iowa. The changes in health technology and the resulting need for health services personnel is one priority issue. Availability of primary health care, especially for indigent Iowans is another. A workshop that would invite 50-60 leaders with primary health cares service delivery interests, is currently being planned for fall 1990. Topics would include interaction of economic development, education, demographics, and health care services.

* Two committees, the Health Care Expansion Task Force, composed of legislators and selected lay persons, and the Governor's Blue Ribbon Committee on the Uninsured, are addressing the major issues of uninsured Iowans. Final reports will be completed prior to the 1991 legislative session.

Some preliminary findings include:

Approximately 220,000 Iowans are identified as "uninsured". This is about 9% of Iowa's under-65 population.

Of The uninsured:

71,000 are below poverty levels (32%)
84,000 are between 100-200% of poverty (38%)
55,000 are above 200% of poverty (30%)

Of the uninsured 18-64 years of age:

92,000 are full time workers-full/part year (57%)
42,000 are part time workers (26%)
27,000 are not in the labor force (17%)

Of the uninsured:

65,000 are in Des Moines and other cities (29%)
155,000 are in remainder of the state (71%)

Low income children with NO well child coverage:

79,000 with private insurance
45,000 with no insurance

* The Maternal & Child Health (MCH) program is administered by the Iowa Department of Public Health (IDPH). There are 23 maternal health centers and 25 child health clinics providing services to nearly all Iowa counties. FY 1990 objectives include:

  Improved access to and provision of comprehensive services to low income and high risk pregnant women.

  Involve family planning agencies to improve perinatal outcomes.

  Improved continuity of care for infants and young children and increase utilization of the EPSDT programs.

* An Iowa Office of Rural Health was established within IDPH in 1989 through Iowa legislative action. This program is looking at a variety of rural health issues. It is also mandated to provide technical planning assistance to rural areas with special focus on health care personnel and service delivery issues. Community involvement is a key ingredient. Through analysis of the current status of the primary health care delivery system, identification of the needs of the community, and gaps in service, a plan for action would be developed.

* Emergency Medical Services (EMS) training and certification programs have been strengthened over the past two years as

a result of state legislation. Training and equipment purchases are supported with state funds.

* State funds and private insurance funds have linked together to establish the "Caring Foundation", a program to provide health care for children who are not eligible for Title XIX services, but are without financial access to health care.

Iowa currently has 27 primary care Health Manpower Shortage Areas (HMSA's). Two new applications are pending for Osceola and Pocahontas Counties.

Of the HMSA's:

* One (Jasper/Marion County area) has a shortage designation of "1". This denotes the most severe shortage.
* Fourteen (14) areas have a shortage designation of "2".
* Medicare populations of two of Iowa's Community Health Centers have a shortage designation of "4".
  - Peoples Clinic - Waterloo
  - Community Health Center - Davenport

According to a recent report from the Northwest Foundation, Iowa had 265,000 metropolitan residents living in poverty in 1987. Non-metro poverty population was over 204,000 at that time. The over-all state poverty rate was 16.4%, while the United States average was 13.9%.

Iowa will have only seven (7) National Health Service Corps (NHSC) scholarship physicians and psychiatrists for 1990-91 assignments. Three will remain during the following year. There is also one loan repayment physician in the state, although several areas have qualified for consideration if physicians become available. Most have been waiting up to two years. The CHC's in Waterloo and Davenport have recruited four (4) volunteer physicians just recently. At the height of the NHSC scholarship program, Iowa had 25-30 physicians assigned throughout the State. Currently about 170 Iowa communities are seeking a family physician. Expansion of both the NHSC loan repayment program for immediate assistance, and the scholarship program for future help is needed. This is one important piece to the solution of Iowa's primary health care service delivery system.

Five Iowa hospitals received federal Rural Hospital Transition Grants in FY 1989. Twenty-eight (28) grant applications, representing 43 rural hospitals have been submitted to HCFA for FY 1990 funding. Four applications came from consortiums of hospitals.

It is apparent that Iowa hospitals view this grant program as another important way to strengthen the Iowa healthcare network. The 1990 Iowa Legislature provided first-time funds of $50,000 for a state physician loan repayment program. A nursing loan repayment program has been in place for two years. A grant application to the PHS for the federal State Loan Repayment Program is soon to be submitted. Matching funds for both the physician and nursing programs will be requested. We understand that current reauthorization legislation has excluded this program. We would ask your assistance in re-establishing this program into the NHSC reauthorization proposal.

Iowa is fortunate to have three strong Community Health Centers located in Waterloo, Davenport, and Des Moines. together they have served over 37,000 patients, many of them indigent, during the past year. We truly appreciate the CHC's and the services they provide.

We believe that the CHC concept is of great value. Expansion of CHC services in Iowa, perhaps in a variety of forms,would further strengthen the primary health care delivery system. It is an economically, reasonable way to provide quality services for all Iowans, and would assist in addressing the critical problem facing the indigent and uninsured.

The western one-half of the state, with thirteen (13) current and two pending HMSA's is without benefit of CHC services. Four (4) HMSA's, with a population of over 60,000 persons, are clustered around Woodbury County. Four other HMSA's, with a population base of over 30,000 individuals, are in and around Pottawattamie County. Development of new CHC's in these areas might be feasible. Expansion of the Charles Drew Health Center in Omaha, which now services some Iowa residents, might also be a viable option. Additional funds provided to Iowa's CHC's might allow them to expand services and their service areas as appropriate. Iowa also has a number of rural hospital that might be considered as possible CHC sites, perhaps as a pilot project.

Given the number of indigent and uninsured Iowans, the widening gap between identified need for and availability of primary care physicians and other health services professionals, we would welcome an opportunity to support the possible expansion of CHC services in Iowa.We would be pleased to have the opportunity to work with the Health Resources and Services Administration (HRSA) and with local communities and health care providers to explore the development/expansion of CHC sites and programs. Iowa has developed a very strong network of providers, organizations, business, government and policy leaders who are interested in the delivery of primary health care services. Working together, we should be able to achieve positive results.

STATEMENT OF ROGER TRACY

Senator HARKIN. Next we turn to Mr. Roger Tracy, director of the Office of Community Based Programs at the University of Iowa, College of Medicine.

Mr. TRACY. Senator Harkin, thank you, Senator Daschle. Thank you for the invitation to join you today. I am pleased to join my colleagues on this afternoon's first panel.

I have been asked to address some specific questions concerning health manpower shortage areas, community health centers, and the National Health Service Corps, as those entities pertain to Iowa. I have brought along some transparencies. I would like to use those in making my points.

Senator HARKIN. Sure, if you have got the proper equipment there.

Mr. TRACY. I think so.

Senator HARKIN. Great.

Mr. TRACY. As was mentioned in the introduction of the panel, I am from the University of Iowa, College of Medicine, and I am based in medical administration at the college. Our office is principally responsible for all of the college's outreach to Iowa communities.

The anchor program is the Statewide Family Practice Training Program, with nine residencies. That program over the past 17 years has retained 60 percent of its graduates for practice in Iowa, with one-half of the graduates locating in communities of 10,000 and under and one-quarter of those graduates locating in the metropolitan area, where our population density is, of course, the greatest.

We have other programs that we are responsible for that make our statewide training program successful; and one of those is the Medical Practice Development Program, which assists Iowa communities, hospitals, and medical groups with their efforts to attract primary care physicians; and that same program provides practice support, particularly with a rural emphasis, but not limited to rural areas, in order to keep the doctors at the locations where they once entered practice.

Other programs that I will be using in making my comments include some unique data bases that are not available in any other State, unique to Iowa, and enable us to track all Iowa physicians in training and those in practice in order to make manpower projections that account for each and every physician, regardless of what he or she is doing. And I will use some of that data in making my comments today.

Starting with health manpower shortage areas, my numbers will match up, I think, pretty closely with Dr. Weaver's numbers. Iowa in January 1990 had 24 health manpower shortage areas; and that number does not include the special populations in Waterloo, Des Moines, and Davenport that are also designated as shortage areas.

The typical way to refer to the shortage areas is level of shortage, and there are four grades. In Iowa there are—one-half of the shortage areas are at level two, which is one of the more intense levels of shortage. So the 24 shortage areas—and we do this review annually. We just started this past week with the 1990 review. So

each of these shortage areas will be reviewed to see whether it should be continued as a shortage area or dedesignated, and all other counties and communities are reviewed to see whether they should be proposed for designation. Again, we do that annually.

Senator DASCHLE. Roger, I am just curious.

Mr. TRACY. Yes.

Senator DASCHLE. Why would Dr. Weaver's map be different, in that there is a lot more blue area on his map than there are colored areas on your map?

Mr. TRACY. I think Dr. Weaver or Amy has the explanation on that. I think where there is a partial county, they picked up the entire county to show that; but, in fact, the discrete boundaries of the shortage areas are displayed on this graphic. So these are the shortage areas.

Senator DASCHLE. I see. So that blue one there is more of a general——

Mr. TRACY. That is more of a general depiction. This accounts for each of the townships that is a part of a shortage area. So this would be—in some instances there are entire counties; but as you can see, not in all instances.

With regard to the priorities for National Health Service Corps placement should additional National Health Service Corps doctors become available through the loan repayment program or through the Scholarship Program as that is once again rekindled, we set priorities annually in cooperation with the HHS region VII office in Kansas City, working directly with National Health Service Corps personnel.

Our top seven priorities for the current—for the 1991 cycle are listed for rural sites on the left of this graphic; and of course annually all of the community health centers are listed as priorities, with Davenport and Waterloo typically having the Corps placements in their community health centers. But for the rural areas, those would be the top seven and their sequence based on individual priority.

And one of the important considerations in Iowa for making this list is not just how intense the shortage is, but whether or not there is a local private system in which to integrate the Health Service Corps position in order to retain that doctor beyond the obligation.

As you heard the numbers today, we will retain two out of those that were placed here, so it is imperative that they become part of a hospital primary care network or a private practice system so they have the kind of professional support and patient population base that will enable the practice to continue beyond the period of obligation. So those would be the priorities.

PLACEMENT OF PHYSICIANS

With regard to how decisions are made with respect to the actual placement of the National Health Service Corps physicians in health manpower shortage areas, it is not necessary to develop that or spend a good deal of effort in designing something. It is already in place, and it has been there for the past 15 years. There is participation by local private physicians, local hospital or community

groups in the individual shortage area, our Office of Community Based Programs, the HHS regional office staff, and the individual National Health Service Corps physician, which is very important that that individual participate in the selection of the site.

So those are the players in the decisionmaking. And again, we use an integration model, which means we have made this placement a part of something that is most likely to be stable and permanent in the long run.

One of the questions I was asked to address was whether or not it would be appropriate for additional community health centers. And as you know, there are both rural CHC's and urban or inner city CHC's.

I will address the question of rural CHC's first. Rural CHC's are not practical in Iowa. There are only 17 such CHC's in region VII, which is a four-State region, and only five of those are rural. All five of those are in Missouri, in southern Missouri. And the reason they are not practical in the other States, and particularly in Iowa, is that we do not have the—relatively speaking, the same level of poverty that exists in southern Missouri or in other States where rural CHC's are practical.

We certainly have the elderly population, as we all know; but we do not have the rural poverty at that level, and we do not have the problem of accessibility that you would find in southern Missouri, where population centers—towns are 60 and 75 minutes from a physician or from a hospital.

And I will come back to urban CHC's in a moment; but to make the accessibility point, we do location analysis studies with software that we have developed, and we have tied that into our physician data base. You can see here, 87 percent of Iowa's population is within 5 miles of a community that has a physician; 93 percent within 10 miles; and the key point here, I think a 15-mile driving distance, where emergency care is a reasonable standard, 99 percent—rounding to the next percent—99 percent of the population is within 15 minutes of a community that has a physician. Now, that does not mean that an individual or a family would use that physician, it means that they are within 15 miles of a community that has a physician.

With regard to hospital distance, if we do the same kind of analysis, 73 percent of Iowans are within 5 miles of a town with a hospital, 81 percent within 10 miles, and 9 out of 10 Iowans are located in places in our State that are within 15 miles of the nearest hospital. And so we simply do not have the same rural situation that you would find in southern Missouri.

Now, returning to the question of additional community health centers, and looking at the urban site, I would say possibly and maybe probably—and my sites would correspond to those that Dr. Eckhoff mentioned—I would see Sioux City as a possible site; certainly Council Bluffs, with a possible relationship in Omaha as a site; and perhaps Dubuque.

You have to have a population base that would be large enough; and I would say that 40,000 or 45,000 is probably the minimum criterion, from the standpoint of a patient population that would be substantial enough to support a community health center in an urban area.

And how important have our CHC's been in our State? They have been very important. It is absolutely important to continue their operation. They serve a patient population that is otherwise not adequately served by the balance of the health care system in the community or in the region.

On the other hand, it would be unreasonable and impractical to expect the private system, meaning the private physicians and the hospitals, to fully accommodate the patient population because of the high cost of taking ambulatory care visits to the hospital; and in many instances, we do not have enough primary care physicians in the inner city, in the urban locations, to take care of even the private-pay patient population.

And to further that point, you can see that both rural and urban areas across the State are actively seeking primary care physicians. This is just family practice, and as of July 1989—and we do this annual survey and produce new graphics annually, so we are in that cycle right now—167 towns were actively seeking family physicians offering more than 270 positions. Those are bona fide positions.

So our population is close to towns with physicians, but most towns are undersupplied, both rural and urban. So it is not practical to think that our private community and our larger cities have a strong enough base yet to take care of the entire population.

So community health centers are very important, and they are at risk. And one of the reasons that they are at risk is that they depend largely on the National Health Service Corps for their professional—their medical professional services, as is true also of our health manpower shortage areas, particularly when the National Health Service Corps had a stronger pipeline and was turning out more physicians before the administration began to wind down the activities of the National Health Service Corps.

As Dr. Weaver said, reauthorization is due this year, and it is absolutely important that the levels authorized and appropriated begin to return to the levels of former years; but the administration's proposal, I think, shows some sign of optimism; and it needs to be at least that high.

And then the National Health Service Corps needs to—particularly in other States—I think we have been pleased with the way things have gone in Iowa—but improved placement and practice support for the individuals who are placed in health manpower shortage areas.

I will stop at that point and field questions if you have any.

Senator HARKIN. Mr. Tracy, thank you very much. In the interest of time, I just have a couple of questions. Dr. Weaver, Iowa's three community health centers are located in the eastern half of the State. Now, your testimony described Iowa's manpower shortage in medically underserved areas. Based on your review of the data, what parts of the State are most in need of additional placement of health centers or National Health Service Corps professionals?

Dr. WEAVER. Well, Senator Harkin, I guess as you have heard from the gentlemen to my right and my left, we would certainly trust their judgment and work closely with them in determining what the health needs of Iowa are.

I think perhaps the difference in the two HMSA colorations show perhaps this is a Washington view, where we look a little more globally. Certainly when you get in the State level, you have to look at where the needs are. So rather than speculate, we would work through our regional office and closely with both the University and the State to say, "Where are your needs?" And given the resources we have, we will try to do the best we can to accommodate that.

RECRUITMENT LISTS

Senator HARKIN. That is sort of my second question. How do you decide where to place these people? Is that through kind of an arrangement with the State? You ask them, take it into account——

Dr. WEAVER. Well, we are in the process right now of looking at the recruitment lists for the National Health Service Corps for the next fiscal year, although the fiscal year and when we recruit is a little off cycle. We need to start the first of July, because that is when residents at least start looking—from a medical perspective, start looking at what they are going to be doing the following July.

We go out to all the regional offices, establish basically the criteria, and have them work with each State and determine in their order of priority what their needs are. And you saw that Iowa list today, and all 50 States and about five other entities, I guess, with the Pacific Basin, Puerto Rico, and the Virgin Islands, and the others for whom we recruit.

Then we come back and compile a list, based on relative need, and then try to decide which of those relative need sites we will use for—that are hardest to fill. And when we do that, we usually target those for scholars; and which of the next list we will use for Federal loan repayment; and then where—of the other ones, where we will certainly assist in recruiting, but we do not have any dollar incentives to work with people to do that.

Senator HARKIN. Mr. Tracy, when you put that overhead up there about how many miles away people are from a doctor or hospital, you look at it, and you think, well, that's not bad. How many of those doctors take Medicaid patients?

Mr. TRACY. I do not have any idea what that——

Senator HARKIN. That should be a—well, you know, because you might live near them, but they may not take Medicaid patients; and there is a lot of them that do not.

Mr. TRACY. Or you may need an obstetrics service and the family physician—and typically we would be talking about family physicians in rural areas—are not doing obstetrics.

Senator HARKIN. We know that is a great concern. And like the hospitals, they may not be able to take Medicaid, or they may not provide the kind of services that you need in a hospital. They may provide a very narrow range of services in those hospitals.

Mr. TRACY. I think the key point with regard to the hospital location is that all hospitals are required to offer emergency service for licensure, and so you would have an emergency service available at the distance that was shown. And that average for Iowans is 12.3 miles to a hospital and 9.5 miles, on average, to a physician.

Senator HARKIN. Now, for emergency purposes, they would have to take Medicaid?

Mr. TRACY. Yes; right.

Senator HARKIN. But nonemergency would not have to, right?

Mr. TRACY. It depends on what service—what service they offer. When it comes to obstetrics, if we just use the residency-trained family physicians, there is a 0.9 probability that if they are in a community under 20,000, they will be delivering babies. In other words, 90 percent of the graduates who are in towns that size provide obstetric services; while on the other hand, we look at those that are in communities of 20,000 or greater, there is only a 4.5 probability. So just over 40 percent of them are delivering babies.

Senator HARKIN. Back off that a second. I guess we are not trying to make—on some of the hospitals, I have heard this before, yes, they will provide emergency services. You indicate they have to. But for nonprimary purposes, for cases that may come in that are not primary, they do not have to, and they do not; and so again, you get back to that same situation where the poor person waits until an emergency case to go in, and it costs the system a lot more money.

Mr. TRACY. Right, I understand that point. This is not—the tables were not to show the range of services, they were to show the proximity of the nearest hospital if the patient or family chose to use the nearest hospital; and the same, again, with the nearest physician.

They may, for whatever reason—a physician does not accept certain payers, the physician does not provide a certain service, they might not choose a physician; but these numbers show the proximity of towns to—that have physicians.

Senator HARKIN. I understand. Dr. Eckhoff, you testified that Iowa could use additional community health centers. Would you in the Iowa Department of Public Health be willing to lead a process that would help identify these areas and work with communities on applications?

Dr. ECKHOFF. Yes; I think that was the thrust of much of what I said; that there are many things going on, and we would be very pleased to work with the Federal Government and with the selected local communities to explore possibilities to do that.

Senator HARKIN. I guess one of the things that I had discovered recently is that—you correct me if I am wrong—that to get the HMSA designation, it has to start out there. They have to request it; the local area has to request it. And many of those people do not understand what that process is and how that process evolves.

Mr. TRACY. That would be true in most States, that the initiative is taken locally; but in Iowa, for a dozen years, the initiative is taken at the State level by reviewing all counties and all communities to make certain that the Iowa areas that need to be designated as shortage areas have been designated, as well as those that are—after doctors locate in the area that should be dedesignated. Then those proposals are sent to——

Senator HARKIN. So the State does that on their own initiative, then?

Mr. TRACY. Yes; we do that in cooperation with the State health department. We make recommendations annually.

Senator HARKIN. Do you also go out and help these counties—once you have found them, do you go out there and help them prepare their applications?

Mr. TRACY. Yes; as a matter of fact, we do the applications in our office. The shortage area applications are done for all of Iowa in our office.

Senator HARKIN. I wonder why we do not do that nationally, then.

Mr. TRACY. Nationally?

Senator HARKIN. Yes; why is it not done in each State?

Mr. TRACY. Because each State would have to have an organization that would assume that responsibility, and in our instance, without compensation. So we just simply provide that as a service.

In other States it is done by offices of rural health or it is done by university offices similar to ours. For example, the University of Arizona. You would find the same thing in Arkansas.

But most States do not have an office to provide rural practice support and physician recruitment and placement, as well as the training programs; therefore, they do not have an interest in providing that at the State level. And then, Senator, you are correct, the community has to take the initiative to find out whether one qualifies; and if it does, it then has to put a letter of application together that would get it designated if it qualifies.

Senator HARKIN. I just learned something new about Iowa. That is good. Sounds like we are ahead of the curve on that one. Senator Daschle?

HEALTH MANPOWER SHORTAGE AREA

Senator DASCHLE. How can you have a health manpower shortage area and not have it be a medically underserved area?

Dr. WEAVER. It is purely a function of the way that the formulas have been set up. They were set up at two different times for two different programs. Just because of the way that the numbers—it is a summation game. So when you look at the four elements for medical underservedness, the cutoff score happens to be 62. And it is the equivalent of golf; the lower the score, more needy. So anything below 62 becomes a medically underserved area.

And health manpower areas were developed with—roughly the major thing that it looked at was physician-to-population ratio. So they are similar, but they are not—they do not always coincide.

Senator DASCHLE. That sounds like a real bureaucratic answer to me. [Laughter.]

Just give it to me in plain English.

Dr. WEAVER. That is the honest answer. I mean it turns out that they were developed at two different times. There had been some proposals——

Senator DASCHLE. I understand that. They could be developed at 100 different times. But If you have a county that has a health manpower shortage—one that has no doctor, for example—it would seem to me that would automatically qualify them as a medically underserved area.

Dr. WEAVER. I think one of the caveats, perhaps, is poverty. There are some areas—and rural America has some of these—that

certainly have the financial wherewithal to support a health care practice or a medical practice. They really do not need dollars. They do not need a grant program. What they really need is a person there to provide those services. And I think that is one of the factors weighted in.

You know, it is the infant mortality rate, percent of the population with the income below poverty level. It is one of the factors that is weighted in with a fairly heavy number in medically underserved areas. So if you had an area that had, you know, a physician/population ratio of 1 to 5,000 but it was in a reasonable economic base, all you need is people; and there a HMSA would work.

So you are correct, it is a little more than just points in time when they were developed. One of them is do you need personnel? And if you do, that is surely a function of numbers. And it does not make very much of a judgment, other than using—dropping it down to 1 to 3,000, if you are in a real poor area or an area with high infant mortality.

The other one says even if you brought in the people, is there a financial base to support a system in the area? So it is weighted heavier, and——

Mr. TRACY. May I take a crack at——

Senator DASCHLE. Please do.

Mr. TRACY [continuing]. Dr. Weaver's comments? They were created under the same title, but two different authorities, so two different programs; and then—and one ahead of the other, and they sort of matured together. The way it is applied in Iowa, we pay very little attention to MUA's. All of our Corps placement, with the exception of CHC's, community health centers, all of our rural placement, and all of our shortage area designations are based on health manpower shortage areas, 3,500-to-1 population-to-physician ratio.

The reason that—there might be a refinement needed to get rid of some of the obscure elements of this; but I think the reason that it stayed on the books and there has not been a big push is that some communities, particularly in other States, would lose their shortage designation—they would not qualify if you were looking just at 3,500 to 1. So there is probably reason to have a second route to qualifying for a designation for those that have a 3,500-to-1 population but yet have some characteristics, in terms of nutrition problems, neonatal—or infant death rates, and elderly, as well as poverty, that would enable the region or the area to qualify under one program but not—or under one criterion, but not the other.

So it is to the advantage to have a second route, I think. For Iowa's purposes, HMSA's have served the purpose for the State.

Senator DASCHLE. Thank you for those answers. Just one other question. You laid out the numbers, and I was not good enough in writing them down quickly enough to fully comprehend what you were giving us with regard to the numbers in the National Service Corps in recent years versus what you expect. What was the budget for scholarships last year in the National Service Corps?

Dr. WEAVER. Last year, as you may be aware, we received permission from the Congress to change—I am grasping at the word here—I want to say reappropriate, but that is not the right word—reprogram—excuse me—2.9 million dollars' worth of funds to do a

scholarship program, which allowed us to do 41 scholarships last year.

Senator DASCHLE. But it was zero from the administration, was it not?

Dr. WEAVER. It started out at zero, yes.

Senator DASCHLE. Zero.

Dr. WEAVER. We did not have any money for a scholarship program.

Senator DASCHLE. So then you got $2½ million——

Dr. WEAVER. $2.9, yes.

Senator DASCHLE [continuing]. $2.9 million for 41 scholarships?

Dr. WEAVER. Yes, sir.

SCHOLARSHIPS

Senator DASCHLE. So now this year, fiscal year 1991, what was the recommendation from the administration on National Service Corps scholarships?

Dr. WEAVER. It is a combined scholarship and loan repayment. It is $64 million. So it compares to $9 million that we had this year. We had $9 million this current year, $8.87, or something like that, for the scholarship, Federal loan repayment, and State loan repayment. That equivalent amount in the President's budget for this year is $64 million.

Senator DASCHLE. And the blend is up to the National Service Corps? Who will determine what the match between repayment and scholarship is going to be?

Dr. WEAVER. Well, it would be a decision within the Department and up to the Corps. I think it is fair to say, because of the pressing needs that we have right now, we look at a fairly aggressive emphasis on loan repayment, because people are needed at sites now, with some buildup of the scholarship program, with hopefully a long-term look at combination of the two.

Senator DASCHLE. How many scholarships, then, do you expect this year?

Dr. WEAVER. This current year—in fact, we will actually have some scholarships in this fiscal year. It is somewhere between 40 and 150. The reason there is that large variation is it really depends on whether we do multiple-year funding out of this fiscal year's appropriation or whether we do single-year funding and then use some of next fiscal year's for that.

Senator DASCHLE. Have you seen any long-term projection from the administration with regard to what they will budget in the next coming years?

Dr. WEAVER. To the best of my knowledge, other than next year's, that is still up for debate within the Department; but certainly there is support within the administration for our continuation of and expansion of the National Service Corps.

Senator DASCHLE. There is? That is good to hear. Frankly, I'm skeptical; and I'm glad to hear that you think there is a lot more support there. From the conversations I have had, and especially in the last few years, the sense I have is that there has not been a very significant amount of support; and as a result, we have seen a diminution over the last couple of years and very low response to

the problems that Iowa and South Dakota and some of these States have. But you feel just cause for optimism?

Dr. WEAVER. Yes, sir; I think not only in dollars, but I think a return to what the approach was when we had larger funding, and that is to not just be solely physician-oriented. I think you will see a return of the team approach and see utilization of nurse practitioners, physicians assistants, and——

Senator DASCHLE. I see. So you would not have any objection to an earmark of some kind for nurse practitioners in the National Service Corps in the future?

Dr. WEAVER. I am certainly excited about having them as members of the team. I would be less than honest to say that a specific earmark is something—we would always rather have the prerogative of doing those balances; but from the point of view of them being an integral part of the future of the National Health Service Corps, I am very excited about that.

Senator DASCHLE. If you could have your druthers, and whatever you finally decided was the number would be ultimately the number, as far as the Bush administration budget, what would you like to see in, say, the year 1994-95 with regard to the number of scholarships for the National Service Corps?

Dr. WEAVER. Total number? I guess the total number—it depends on how successful we are in the next few years with our Loan Repayment Program. One of the things that we have found is that loan repayment to date—albeit it is only in year 3, so I think it is a little too early to tell—it has not appeared to be quite as successful in many areas as the scholarship program had been in getting those people in those most difficult to fill areas.

There is a counterbalance to that, of—which one of the current assigns in the Corps who is leaving Iowa—he and I were chatting about this before. The counterbalance is by doing that, you may also increase the possibility that people will not stay after their period of obligated service; and that is the sort of catch 22 of the Corps.

I think we need some sort of stable cadre of scholarship recipients throughout the system; and whether that ends up in the 3 to 4 to 500 range of people, I think that is the sort of numbers that you might start to take a look at and say these are some numbers that—with a very important caveat. I think they need to be people who are interviewed up front and understand that it is a scholarship and not a loan; that since 70 percent of the health manpower shortage areas currently are in rural America, they very likely may practice in rural America, at least for their initial assignment.

And they need to understand that and do what we started last year with the scholarship program, and that is we instituted an interview program. So not only do we plan to interview people at the beginning, but we plan to stay in touch with them throughout their educational experience. So hopefully our outcome will be a little bit better. So I guess somewhere between 400 and 500 would be the place——

Senator DASCHLE. That is interesting. The impression I have—and I am certainly far from being an expert—is that when we had that peak number—I thought it was 22, and you say it was 16, so I stand corrected——

Dr. WEAVER. That was the maximum number of people we had come out in any given year——

Senator DASCHLE. OK.

Dr. WEAVER [continuing]. To serve a scholarship obligation. We were up to a little over 3,200 people during our peak year.

Senator DASCHLE. Thirty-two. I knew we had 32, and it seemed to me that the utilization of every one of those 3,200 doctors was well documented. They were there, and they were on the job, and they were providing the service, and it was really a fantastic program.

It seems to me that since that time, when we had 3,200 doctors out there working in the Corps, that if anything, the need has grown. I mean we are in far worse times now in primary care shortage areas—at least if South Dakota is any indication—than we were back then, and we had 3,200 out there.

And your answer to me was that maybe 400 or 500 may be all we really have to have. And it sure seems to me that you could make a strong case for five or six times that number if you are going to serve these areas like we were once serving them through the Corps.

Dr. WEAVER. If I may clarify, there is a very important caveat that I tried to put in the front of that, and that is, Senator, how successful we are with the loan repayment program. If, indeed, we can do a better job as a loan repayment program, it has a tremendous advantage; and the advantage of the loan repayment program is people have already made a commitment to a primary care career, and we can now help them get into the areas most in need. And so the assumption with the numbers that I talked about is we continue to have very large and aggressive, both State and Federal, Loan Repayment Programs that will help meet a lot of that need, because the 500, indeed, would not make the entire——

Senator DASCHLE. I thought you said—and I agree with what you said earlier—that the Loan Repayment Program really has not shown much success. I mean we really have not seen the kind of response in the Loan Repayment Program that we had originally in the Scholarship Program; and if that is the case, I do not see anything that will change that.

Maybe there is something there; but it seems to me that having a scholarship program has been demonstrated to be far more effective than the Loan Repayment Program; and if that is the case, we ought to start understanding that and projecting our needs through scholarships, rather than through loan repayments. Anyway, I have taken enough time. Thank you.

FEDERAL/STATE MATCH

Senator HARKIN. Well, I think, again, the loan repayment—if I might just throw in my nickel's worth here—the Loan Repayment Program and getting that Federal/State match in there—which we are going to make sure we keep that in there—gets them out there right now. You get them out there immediately. You can actually tap into it right now.

The scholarship thing, we have got to rebuild the pipeline. We had, in 19—I was just asking Amy. I think the peak year was 1978, 1979, 1980, we were putting in about $130 million a year. That has

gone down to $9 million, right? So that whole pipeline has been shut off. It takes some years to build that back up.

It is just, again, my nickel's worth. I think you are going to have to rely on that Loan Repayment Program. Hopefully it will work a little better. Get the people in immediately. At the same time, start backing up—get back up to that $60 how many million—$64 million level, boost that up again the next year and the year after, and start getting that pipeline built up with the Scholarship Program back up in the future.

OK. Thank you very much, everyone. I am glad you asked that question about those charts. I was looking at those this week, and I thought it was just me. I could not understand it either. I have got a better picture now. I could not understand. Thank you all very much. I am sorry we are going to kind of have to hurry here a little bit.

STATEMENTS OF:

DR. BERY ENGEBRETSEN, DIRECTOR, POLK COUNTY HEALTH SERVICES, BROADLAWNS MEDICAL CENTER, DES MOINES, IA

DR. SARAH GORDON, PEOPLES COMMUNITY HEALTH CLINIC, WATERLOO, IA

COLLEEN BUTLER, R.N., COMMUNITY HEALTH CARE, INC., DAVENPORT, IA

INTRODUCTION OF PANEL 2

Senator HARKIN. Second panel, I would like to call up Dr. Bery Engebretsen, who is a physician with the Broadlawns Medical Center in Des Moines. Broadlawns Medical Center has been providing services since 1981 and currently serves over 11,000 people in the Des Moines area.

Dr. Sarah Gordon is a physician with the Peoples Community Health Clinic, right here, this one. Dr. Gordon came to Iowa with the National Health Service Corps and remained at the Peoples Clinic after completing her required service obligation.

I hope Dr. Gordon can tell us what will work to keep other doctors in service. She has got the secret. Oh, Amy just told me you married Ron Kemp. [Laughter.]

Now I understand. Colleen Butler is a registered nurse and certified pediatric nurse practitioner at Community Health Care, Inc., in Davenport. She is the coordinator of the Child Health Program.

So I appreciate, again, all of you taking time from your busy schedule and some of you coming a great distance. And again, I have read some of your statements here on the way up. I read Bery Engebretsen's and also Colleen Butler's statement that you had; and so again, I will ask you, if you could just summarize briefly—tell us the two or three things you think you would like to have us understand and walk out of here with.

STATEMENT OF DR. BERY ENGEBRETSEN

So I will first turn to Dr. Engebretsen.

Dr. ENGEBRETSEN. Thank you. I have spent the entire 22 years of my professional career in community health centers of one sort or another, both in urban and rural areas; and what I think I would like to do is take off on something that Senator Daschle said just a

moment ago; that it is his perspective that the need has increased in recent years. And I would like to suggest that during the decade of the 1980's, in particular, that the need for health services to underserved Americans has increased rather dramatically.

When I first came to Broadlawns in 1980 to start the community health center there, the institution as a whole had total visits of approximately 100,000 per year. By the end of the decade of the 1980's, that number was up to 160,000 visits a year; 30,000, approximately, of those visits in our community health center.

Some 25 percent of our patient population at the current time has a significant subdisease problem that we are aware of. In our jail population, that figure is probably 80 percent. We serve approximately 2,000 homeless individuals in the Des Moines area, and many people have been shocked to find that there are that many homeless people in Des Moines.

We have a small, at the moment, but growing, problem with HIV or AIDS; but we are very concerned, both in Des Moines and Waterloo, that currently we are seeing epidemics of syphilis and hepatitis B among individuals who are IV substance abuse users or prostitutes and some gang members. This is a setup for the HIV virus.

Iowa has a small migrant program that was designed many years ago to solve—or to serve approximately 1,000 migrants. The dollars have shrunk. The number of migrants coming into the State each year is now approximately 4,000. So a program that was designed to serve 1,000 migrants is now trying to serve 4,000 migrants.

I would like to at this point interject, as a side comment, a response which we discussed a moment ago regarding rural areas in Iowa and the fact that there appears to be geographic access. I think Senator Harkin was getting to this when he asked about Medicaid access to physicians in hospitals. You have to remember that not all of Iowa's poor are currently on a Medicaid program there. Many, many people are not yet Medicaid eligible, and so there is a significant problem with financial access in rural areas.

Also I would like to differ just a bit with one of my predecessors, Mr. Tracy, in the fact that community health centers cannot serve rural America. There are probably at least two or three different routes that that could happen. For example, Will Rodgers in Davenport is currently experimenting with satellites of his community health center in rural areas.

NURSE PRACTITIONERS AND PHYSICIANS ASSISTANTS

Another possibility is looking into extended use of nurse practitioners and physicians assistants in rural areas; and the third possibility would be the use of some sort of voucher program, such as the migrant program currently does.

So I think that community health centers could play a role, as they do in other parts of the country, in rural areas.

You have heard most of the figures. A couple that were not mentioned is that since 1978, Iowa has lost 52 family practitioners, net loss, in the State. The number of doctors—the number of towns with one or more physicians in it has dropped from 297 to 264

during that same time period. You have heard the figures having to do with the Corps.

PREPARED STATEMENT

I guess, just in summary, I would like to say that although I have watched the sophistication of community health centers, both in a professional sense and managerial sense, increase rather dramatically during the last decade, the need for their services has also increased rather dramatically.

Senator HARKIN. Dr. Engebretsen, thank you very much.

[The statement follows:]

STATEMENT OF DR. BERY ENGEBRETSEN

I would like to thank the Committee and Senator Harkin for offering this opportunity to present information on health care concerns that are of vital importance to myself, my organization and my community.

Community Health Centers provide basic health services to 6,000,000 of the identified 37,000,000 Americans that are underinsured or uninsured. In our Community Health Center, located at Broadlawns Medical Center in Des Moines, Iowa, we serve approximately 11,000 of those individuals. The three Community Health Centers in Iowa serve approximately 30,000 of the identified 220,000 individuals in Iowa that fall into the category of under or uninsured. This would suggest there are still 190,000 people in Iowa with uncertain access to health care. When I came to Broadlawns in 1980 to develop our Community Health Center, there were 100,000 annual visits to the entire medical center complex. By the end of the decade of the 1980's that volume had increased to 160,000 annual visits. This figure shows that in the 1980's the need for health care among the under and uninsured has increased by a startling 60% in my community.

Our Community Health Center, which we call the Primary Care Center, provides the full spectrum of primary care services as well as homeless health care, homeless chronically mentally ill health care, refugee health services, employee health services, substance abuse services, and HIV related primary health care services as well as coordinating care for the full spectrum of secondary and tertiary health care. The new Director of the Health Resources Services Administration (HRSA), Dr. Robert Harmon, has recently called for increasing cooperation among Community Health Centers and existing local public health and county/city health programs. We have, from our onset, always enjoyed a supportive and cooperative arrangement with Broadlawns Medical Center, the county facility responsible for indigent health care in Polk County. They support our organization in a substantial way with County dollars as well as administrative and clinical services.

Despite this substantial local support, we find our programs constantly pressed to meet an ever increasing demand for primary care services. For example, it currently takes three weeks to get an appointment with one of our providers in the Primary Care Center. We have been able to make little dent in this waiting time over the last several years. The Waterloo and Davenport Community Health Centers have both had to close their practices to new patients for extended periods of time in the past because of demand for services beyond their capacity.

In addition to the demand for basic primary care services, we also have heavy demands for services from two specials populations and an increasing demand for services from a third. The first of these special populations is the substance abuse population or the term that we prefer, the chemically dependent. We estimate that 25% of our patient population has serious problems related to substance abuse. We are barely able to scratch the surface of this increasing need. The treatment component of last fall's Federal drug legislation contained no programs for expansion of care to drug abusing populations such as ours by comprehensive health programs such as ours. Instead the Legislation favored the existing systems of State administered Block Grant Drug Treatment Centers. Unfortunately, in our community as in most communities these programs are full and they are full with the conventional male, intravenous drug using, Court referred clients. We are beginning to see an increasing number of young pregnant women who are addicted and whose addiction carries significant risk to the pregnancy as well as to their own health. Recent evidence suggests that significant percentages of these infants will grow into children with developmental disabilities. We need to have the ability to train our professional staff in screening and diagnosis of these problems along with the staffs of our cooperating perinatal programs, to expand the outpatient treatment delivery capacity of our programs, and to be

able to contract with existing treatment facilities for inpatient and other intensive services for this growing high risk population. Tying a case management program for these women onto our existing comprehensive care program could be accomplished easily at minimal cost.

Our Homeless Outreach Project cares for approximately 2,000 of the nation's 350,000 homeless individuals treated in homeless projects. With State dollars we have been able to add a Mentally Ill Homeless component. We and many providers in Polk County have been amazed at the need for services that exist in our community unknown to most health professionals. The Homeless Project provides primary care, mental health care and substance abuse services at eight sites within the Des Moines community. In addition, considerable time is spent in the streets, along the rivers and in other areas where the homeless congregate.

Our HIV related problems have been small in numbers to date but steadily rising. More troubling is the current epidemic of syphilis in both Waterloo and Des Moines. These cases are appearing in prostitutes and crack users. If the HIV virus makes it's way into these populations, both of these Iowa communities may see an increase in HIV related problems. Nationally, as we all know, HIV related care is crushing the public sector health programs. We would like to prevent this happening in our communities by focusing on HIV prevention in the sexually promiscuous and drug using populations that we have identified.

Iowa's small migrant program was designed many years ago to care for the 1,000 migrants then estimated to travel to the state each year. The current estimate of migrant and seasonal farm workers in Iowa now is estimated at 4,000 and growing. Our state's program cannot carry out its mission to 4000 on a budget designed for 1000.

In contrast to most Community Health Centers around the nation we serve a population over 65 years of age that represents 13% of our total patients. As you are well aware, this population uses up a disproportionately large amount of the total health care dollar.

Despite these increasing demands for services at a time of shrinking resources we feel we have made some significant contributions to the health of our community and consequently the social and economic burden on our larger community resources. For example, we have heard from individuals within the criminal justice system of Polk County that they have seen a significant decrease in the return of certain individuals into the criminal justice process. Specifically, they are referring to individuals with chronic mental illness that are cared for in our Homeless Project. Though we have no concrete data, it is the feeling of these criminal justice representatives that that decrease is directly related to the work of our Homeless Project in keeping certain people, particularly the mentally ill, out of the jail system.

I should state that the information provided above relates specifically to the Polk County and Des Moines community. It does not relate in any great detail to the situations of the two other Iowa Community Health Centers nor to the Iowa Migrant Project. In particular, it does not address the problems of physician and other health professional manpower shortages. Because of our unique and fortunate relationship with the larger Broadlawns Medical Center, we have not had a critical shortage of key health professionals through the years. However, in both Davenport and Waterloo as well as literally hundreds of rural communities throughout the state, manpower is a constant concern. Since the near demise of the National Health Service Corps, this health professional shortage is rapidly becoming a critical issue. Nationally within the coming two years there will be approximately 800 vacancies currently filled by National Health Service Corps physicians. There is the potential for as many as 200 Community Health Centers to have to close their doors because of the inability to attract physicians. Many of these

centers are in communities that have been traditionally the most difficult to recruit for. There is a clear need for Community Health Centers to increase their attractiveness to physicians as practice sites. This issue is currently being addressed on many levels by the Community Health Centers and their organizations. But it is clear that without the National Health Service Corps' physicians currently available, that many of these communities will be without physicians and we will have returned to conditions not unlike the 1960's when millions of people throughout the nation did not have ready access to basic health services.

In Iowa, the office of Community-based Services has reported a net loss of 52 family physicians from the state since 1978 when reporting began. If we look at the last five years alone the net loss is 71. Additionally, over the last decade the number of towns with at least one doctor has dropped from 297 to 264. This is despite an excellent network of family practice training programs that retains 59% of its graduates in the state.

Iowa is trying to contribute its share towards alleviating the health professional shortage. The Iowa Legislature and Iowa/Nebraska Primary Care Association have worked hard to get a beginning commitment of $50,000 as matching money for a state loan repayment program. This can be matched by $200,000 from HRSA to repay student loans for Health professionals who agree to practice in Health Manpower Shortage Area.

We in Iowa do not like to admit to being unable to care for our own, but it is clear that many Iowans in both rural and urban communities have significant barriers to their access to health care imposed by either geographic or financial constraints.

With this as background, I would like to urge you to support the following specific proposals.

1. Work for the integration of the various categorical health programs into an integrative package of comprehensive health care programs such as provided by Community and Migrant Health Centers. The issues of homelessness, AIDS, and substance abuse including "cocaine babies" are often part of a spectrum of health problems that affect the same individuals. Comprehensive programs that can integrate all of these services into a primary care approach are much more efficient from the health services delivery perspective as well as from the patient perspective since the patient does not have to deal with multiple providers to seek treatment for their health care needs.

2. We recommend that you support basic Community and Migrant Health funding at the $560,000,000 level.

3. Homeless health care needs authorization at the $66,200,000 level to continue existing programs. As you recall, $12 million of the current budget was advanced from next years budget. The amount needed to maintain current levels of service is $50 million, $12 million has been borrowed, and the extra $4.2 would serve some of the 22 new projects approved but not funded with requests totaling $6 million.

4. The expansion of the National Health Service Corps needs to occur to address serious current and pending health professional shortages. This should be at the recommended level of $130,000,000.

5. AIDS treatment needs to be expanded from its current $10,800,000 proposed for Community and Migrant Health Centers to $50,000,000.

6. Substance abuse for Community and Migrant Health Centers could be accomplished at the $44,000,000 level if the Presidents proposal for cuts of $44,000,000 in the ADAMHA Drug Treatment Programs were transferred to Community and Migrant Health Centers.

STATEMENT OF DR. SARAH GORDON

Senator HARKIN. Dr. Gordon.

Dr. GORDON. Thank you. First, there was no prenuptual agreement for me to stay at Peoples.

Senator HARKIN. You know what I was thinking? Maybe we have got the secret for this; that every center director would be single and bright and unmarried, and then bring in a doctor of the opposite sex, however that works.

Dr. GORDON. There were some factors, though, that influenced my decision to stay on at my Corps commitment, and I would like to share that with you now.

Senator HARKIN. Please.

Dr. GORDON. For the past 3 years, as you know, I have practiced here at Peoples Community Health Center in Waterloo. The road to Iowa for me started in Kansas City, MO, where I did my medical education and also my residency training.

During my high school years, I was interested in a career in medicine, and I initially planned to attend a traditional 4-year premedical program, followed by a traditional 4-year medical school. But during my senior year in high school, a representative from the Western Missouri Area Health Education Consortium, WMAHEC, as it was commonly known, contacted my high school, which was a small rural school in central Missouri, regarding a new program at the University of Missouri, the Kansas City campus, which was a 6-year medical school leading to a combined degree in an undergraduate field and a doctor of medicine.

I applied for this program, was accepted, graduated in 1982 with a B.A. in biology and an M.D. And here I would just like to interject that probably a big part of why I stayed was some of the experiences that I had with my advisors and the close interaction between AHEC and my particular medical school.

During my medical school years, I had the opportunity to study abroad for several months the Chinese system of medicine and the United Kingdom system of medicine. I also spent some elective time in rural Missouri studying health care delivery in my home State.

During my fourth, fifth, and sixth year of the 6-year program, I received a Corps scholarship. My first Corps assignment was an 18-month placement as a private practice option with an inner city Kansas City group. The group closed the practice when I was 18 months into my 3-year payback, and I was then assigned to Peoples Community Health Clinic in March 1987. I completed my Corps obligation in August 1988 and I continued to practice full-time at the clinic subsequent to that.

I have to say that my practice here has been a challenging and fulfilling experience for me. Our community, as you are both aware, has a title V maternal child health project, the Allen Women's Center, which is located in the same physical facility that the Peoples Clinic is housed in.

My pediatric colleagues and I provide in-hospital newborn services and well-child care for a large number of the infants that are born to mothers enrolled in this project. Waterloo is very fortunate to have quality, both level-1 and level-2 nursery and obstetric serv-

ices and to—again, the staff pediatricians here provide the gamut of services to the newborn population.

The clients served by the title V program include many high-risk women, including pregnant adolescents, substance abusers, those mothers with chronic or pregnancy-related medical complications of pregnancy, and many other serious complications.

When I completed my residency at the Children's Mercy Hospital in Kansas City, MO, some of my mentors in perinatology sort of lamented the fact that I spent about a year of my training in perinatal training, because—and I quote here—"you will never use that in private practice."

But it is sad to say, but true, that rarely does a week go by that we are not confronted by a drug-addicted mother here, a preterm infant, a low birthweight infant, an infant with acquired serious abnormalities or acquired serious congenital abnormalities at birth.

And likewise, my practice outside of pediatric—or pardon me—the neonatal period encompasses a wide range of pediatric care, from just routine health maintenance, well baby care in children, to management of very serious chronic diseases in children.

We follow kids with complex congenital heart disease, kidney disease, pulmonary problems, endocrinology disorders, and many other serious illnesses.

The ranging complexity of the medical problems as presented by our population continues to amaze me. I thought when I left the academic setting that would be the last complex or interesting case I ever saw, but that is not the case at all. My associates and I also have a great interest in developmental pediatrics, and we care for a significant number of developmentally disabled children. Medical care of these special needs children has definitely been enhanced by the range of support services that are available here at the clinic, and also case management services that we have developed at the clinic.

I would have to say, in terms of my practice satisfaction, how I feel I can best interact with my clients and how my services can best be utilized has been a very, very strong factor in my retention.

I believe that my practice in the community health center well serves the needs of my clients and their families. Financial barriers to care has been reduced—not eliminated, but reduced. Nutrition services are available through the clinic. There is a full-time social worker who works very closely with the medical staff to provide needed services to families.

Two special projects, the Perinatal Program and the Children With Special Health Care Needs Project, provide the case management services I mentioned earlier for a number of our pediatric clients.

Also I am fortunate to have the opportunity to work closely with another correlated title V project here in the U.S. West Building, the Blackhawk County Health Clinic. I serve as medical advisor for this organization, and we share responsibility for delivery of health maintenance care to a number of pediatric clients in the community.

My days are full here. We provide 40 hours of clinic time weekly, a 24-hour-a-day answering service, and comprehensive pediatric

hospital services. These services were not provided by our community health center prior to 1987.

Despite these systems of care being in play from this community, a number of Iowa and America's children continue to be medically underserved. Frank Osky, who is chairman of pediatrics with Johns Hopkins, edits a journal called "Contemporary Pediatrics." In March 1989 he wrote an editorial on special health care concerns he has about the pediatric population that I would like to share with you.

In his editorial, he refers to the graduating class of the year 2000; and I quote:

> The class of 2000 includes children who entered grammar school this past fall and should graduate from high school at the turn of the century.
>
> In this class one in four is poor, one in five is a risk of becoming a teen parent, one in six has no health insurance, and one in seven will not complete high school.
>
> This class has already surmounted many obstacles. They were born in a country that ranks 19 in infant mortality. An infant born in Cuba or Bulgaria has a better chance of living than a black infant born in the United States.
>
> About 10 percent of the mothers of these children received no prenatal care, and about one in four received inadequate prenatal care. The children of the class of 2000 confronted a 15-percent chance of being born prematurely, despite the fact that we know that adequate prenatal care reduces the risk of prematurity and costs far less than the care of an infant in a level-3 nursery.
>
> Some 25 percent of the class of 2000 reached the age of two without receiving adequate immunization against polio, measles or rubella. I feel that for every dollar we spend on immunizations saves $10 in health care costs when a child becomes ill with a disease that we can prevent.

COMMUNITY HEALTH CENTERS

I believe that community health centers are essential in helping to provide solutions to these problems.

Central to physician services is the issue of physician or provider recruit retention. The National Health Service Corps Scholarship Program that I participated in is a short-term recruitment of positions for servicing medically underserved areas, but now nearly a defunct capacity in the Corps Scholarship Program has left a huge gap in our ability to deliver services to a population with such great medical needs.

I believe that recruitment and long-term retention of physicians will depend not only on a competitive salary and benefit schedule, but also on development of a commitment to the community health center practice by that physician.

My practice is not the career I would have experienced had I chosen a suburban private practice opportunity or an academic career. I deal with a different set of challenges than many of my colleagues in private practice here in this area.

I believe that community health centers provide services to clients who otherwise would find these services difficult or impossible to obtain.

It has been said that the State of the Nation can be measured by the health of its children. And for the sake of improving the health of Iowa's and America's children, I ask you to thoughtfully consider legislation to improve funding for both community health centers operations and physician recruitment retention efforts. Thank you.

Senator HARKIN. Thank you very much, Dr. Gordon. Very good.

STATEMENT OF COLLEEN BUTLER

And next, Miss Colleen Butler, registered nurse, of Community Health Care, Inc., Davenport.

Ms. BUTLER. Thank you. I appreciate also the opportunity to speak with you today. I have been working at Community Health Care for the past 13 years and have seen changes over the years. Our agency receives money both from the Federal Government, the State government, and also has local contracts.

The percentage of breakdown on funding services is 51 percent from Federal grants, 31 percent from patient revenue after discount, 10 percent from county grants, and 7 percent from State grants, 1 percent from other sources.

We enjoy the privilege of having a comprehensive primary health care system that provides physician services, family practice, pediatrics, OB/GYN, dental services, pharmacy, lab, x ray, nutritional counseling, health education, and social services. We provide the service based on a sliding fee schedule and are currently serving approximately 18,000 active patients who make approximately 55,000 visits to our clinic on an annual basis.

Over 90 percent of our clients have income levels below 150 percent of the Federal poverty level. Approximately one-third of our population has no insurance and is at the low end of our sliding fee schedule. Another approximately one-third are eligible for Medicaid; and the remainder are a combination of self-pay, partial or full insurance, and Medicare.

Community Health Care has been providing services to the community since 1976. Some of the unique aspects of our program are the multiple funding previously mentioned and the variety of programs that we are able to offer, including child health, well elderly, jail health, and STD diagnosis and treatment.

One of our unique features is the provision of a Quad Cities sexual abuse diagnosis center for children. In this program we work very closely with other community agencies to provide care for these special forms of child abuse.

Recently Community Health Care has taken on the health services for the communities of Lowden and Lost Nation, IA. These are rural communities located approximately 40 minutes northwest of the Quad Cities. These communities recently lost the physician who worked at the clinics developed by the communities.

We have been able to continue those services on an interim basis through the deployment of our staff to cover those offices on a 2-day-a-week basis with a physician and a physician's assistant.

We have submitted an urgent supplemental grant request to assure the full-time placement of a physician and a nurse practitioner in these communities. We hope to hear shortly on the success of that request.

There are many communities throughout Iowa, much like Lowden and Lost Nation communities, that are desperate to have a physician practicing in their community providing the necessary primary health care services and referral to specialty and hospital care in our communities. The Lowden and Lost Nation communities are designated health manpower shortage areas and did receive staffing through the National Health Service Corps for many

years. That physician remained in the community beyond his obligation. His eventual association with a large group practice led not to additional support out of the group, but the closing of the practice when financial matters led them to consolidate their practice in the city where they maintain their base.

This is not atypical in the private-sector approach to health care in the rural areas, where the major consideration is financial viability, rather than community and patient needs.

Certainly in these decisions little or no thought is given to indigent patients, let alone the publicly or marginally insured. Our experience and involvement with the maternal and child health centers throughout the State also leads us to believe that there are many communities that lack in referral sources for the patients for general health maintenance.

We envision the integration of community health center dollars and services into these communities and programs in a way that could be mutually supporting.

We also see in our major population centers of Burlington, Ottumwa, Council Bluffs, Sioux City, Fort Dodge, Mason City, Cedar Rapids, Dubuque, and Clinton, a potential need for a community health approach to meeting health needs of indigent and low income. We would suggest a survey of the needs that assured input from the grass roots to be conducted to determine unmet needs in these areas.

It is indeed unfortunate that the National Health Service Corps has declined to its current level. At one time Community Health Care relied strongly on the Corps for its supply of physicians, physicians assistants, and nurse practitioners, as well as other practitioners, including our dentists and speech pathologists. This program has also suffered with dissatisfaction on the part of the practitioners who have come through the Corps, communities who have had Corps placed there, and many of the programs that have had to work with Corps placements.

Much of this dissatisfaction comes through the method of placement in communities of highest need and the type of providers that can be placed there depending on demographics.

We certainly believe that communities should have to apply and be approved as a potential site and that some sort of priority ranking must occur. However, in the long run, we believe that the highest potential for placement success takes place when the candidate's own desires and the desires of the family are taken into consideration.

Perhaps a system that allows for a higher incentive, either in loan forgiveness or salary, to individuals locating in the high-need areas would encourage a better placement success. Certainly the negative impact of a forced placement has been felt throughout the country.

We would certainly support continuation and need for the National Health Service Corps. Of Community Health Care's six physicians, two are graduates of the Corps and have decided to stay on in the community. Our continuing need for physicians at our base operations in Davenport, as well as the Lowden/Lost Nation area, would be strengthened by the ability to utilize National Health Service Corps physicians or the loan forgiveness program.

PREPARED STATEMENT

I want to thank you for the opportunity to be able to present this testimony. Iowans enjoy a good quality of life, and this would be further enhanced by the continued deployment of resources to meet the needs of those whose access to health care services is limited by income or location.

[The statement follows:]

STATEMENT OF COLLEEN BUTLER

My name is Colleen Butler; I am a registered nurse practitioner, and Child Health Coordinator of Community Health Care, Inc., a private, non-profit community health center whose mission is to provide comprehensive primary health care services to the citizens of the Quad Cities in an efficient, dignified and personal manner, regardless of their ability to pay. We are funded by the federal government as a community health center under Section 330 of the Public Health Service Act and Section 340 for health care for the homeless; by state government as a child health center under the Maternal Child Health Block grant; by the State Department of Public Health for the operation of Well-Elderly Clinics throughout Scott County; and have contracts with the Scott County Board of Supervisors to provide primary health care services to County relief clients, inmates of the adult and juvenile facilities in Scott County; discretionary funding for subsidy of low-income and under-insured Scott County residents; and, finally, contracts with the Scott County Health Department to provide diagnosis and treatment of sexually transmitted diseases. The percentage breakdown of funding sources is: 51% from federal grant; 31% from patient revenue (after discounts); 10% from county grant; 7% from state grant; 1% from other sources -- donations, interest, Bethany Home contract. We enjoy the privilege of having a comprehensive primary health care system that provides physician services (family practice, pediatrics & OB-GYN), dental services, pharmacy, lab, x-ray, nutritional counseling, health education and social services. We provide services based on a sliding fee schedule and are currently serving approximately 18,000 active patients who make approximately 55,000 visits to our clinic on an annual basis.

Over 90% of our clients have income levels below 150% of the federal poverty level. Approximately 1/3 of our population has no insurance, and is at the low end of our sliding fee schedule. Another approximately 1/3 are eligible for Medicaid, and the remainder are a combination of self-pay, partial or full insurance, and Medicare.

Community Health Care has been providing services to the community since 1976. Some of the unique aspects of our program are the multiple funding, previously mentioned, and the variety of programs that we are able to

offer, including child health, well-elderly, jail health, and STD diagnosis and treatment. One of our unique features is the provision of a Quad Cities Sexual Abuse Diagnosis Center for Children. In this program, we work very closely with other community agencies and the court systems to assure the proper diagnosis and treatment of individuals suffering from this form of abuse.

Recently, Community Health Care has taken on the health services for the communities of Lowden and Lost Nation, Iowa. These are rural communities located approximately 40 minutes northwest of the Quad Cities. These communities recently lost the physician who worked at the clinics developed by the communities. We have been able to continue those services on an interim basis through the deployment of our staff to cover those offices on a 2-day-a-week basis with a physician and a physician assistant. We have submitted an urgent supplemental grant to assure the full-time placement of a physician and a nurse practitioner in these communities. We hope to hear shortly on the success of that request.

There are many communities throughout Iowa, much like the Lowden/Lost Nation community, that are desperate to have a physician practicing in their community, providing the necessary primary health care services and referral to specialty and hospital care in other communities. The Lowden and Lost Nation communities are designated health manpower shortage area and did receive staffing through the National Health Service Corps, and for many years that physician remained in the community beyond his obligation. His eventual association with a large group practice led not to additional support out of the group, but the closing of the practice when financial matters led them to consolidate their practice in the city where they maintain their base. This is not atypical in the private-sector approach to health care in the rural areas where the major consideration is financial viability rather than community and patient needs. Certainly in these decisions little or no thought is given to indigent patients, let alone the publicly or marginally insured. Our experience and involvement with the Maternal and Child Health Centers throughout the state also leads us to believe that there are many communities that lack in referral sources for the patients for general health maintenance. We envision the integration of community

health center dollars and services into these communities and programs in a way that would be mutually supporting.

We also see in our major population centers of Burlington, Ottumwa, Council Bluffs, Sioux City, Fort Dodge, Mason City, Cedar Rapids, Dubuque and Clinton a potential need for a community health approach to meeting health needs of the indigent and low-income. We would suggest a survey of needs that assured input from the grass roots to be conducted to determine unmet needs in these areas.

It is indeed unfortunate that the National Health Service Corps has declined to its current level. At one time Community Health Care, Inc., relied strongly on the Corps for its supply of physicians, physician assistants, and nurse practitioners, as well as other practitioners, including dentists and a speech pathologist. This program also has suffered with dissatisfaction on the part of practitioners who have come through the Corps, communities who have had Corps placed there, and many of the programs that have had to work with Corps placements. Much of this dissatisfaction comes about through the method of placement in communities of highest need and the type of providers that can be placed there depending on demographics. We certainly believe that communities should have to apply and be approved as a potential site, and that some sort of priority ranking must occur. However, in the long run, we believe that the highest potential for placement takes place when the candidate's own desires and the desires of the family are taken into consideration. Perhaps a system that gave a higher incentive, either in loan forgiveness or salary, to individuals locating in high-need areas, would encourage a better placement success. Certainly the negative impact of a forced placement has been felt throughout the country. We would certainly support the continuation and need for the National Health Service Corps. Of Community Health Care's six physicians, two are graduates of the Corps and have decided to stay on in the community. Our continuing need for physicians at our base operations in Davenport, as well as the Lowden/Lost Nation area, would be strengthened by the ability to utilize National Health Service Corps physicians or loan forgiveness.

I want to thank you for the opportunity to be able to present this testimony to the Committee on Appropriations. Iowans enjoy a good quality of life, and this would be further enhanced by the continued deployment of resources to meet the needs of those whose access to health care services is limited by income or location. Your continued interest and support of these issues is greatly appreciated.

COMMUNITY HEALTH CENTER

Senator HARKIN. Thank you all very much. I am sorry, our time is just running out. I just had one—Dr. Gordon, it almost sounds like you were describing something I went through when I got out of school. I went through a legal services program. It sounds like being in a community health center is much like that. Very challenging. You get a wide variety of different case loads you might not get in private practice, when you are selecting who your patients or your clients might be.

I have often told a lot of young people that were going to law school if they really want to get an education in a hurry, go into legal services. It sounds like the same with community health centers, where the need really is, and you can build up a lot of expertise in dealing with primary care.

Again, I do not have any questions, other than to thank you for being here and thank you for your testimony.

Senator DASCHLE. If you could just submit one for the record—this would take a while, and I enjoy discussing it, but I think if you could just—I would be interested in knowing how you think a single payer system would serve community health clinics. Do you think a single system would be advantageous nationally from a perspective of national community health clinics? And if so, how would that be advantageous; or if they would be detrimental. If you could just think about that and submit it for the hearing record, I would appreciate that. Thank you.

STATEMENTS OF:

PATRICIA BRADENBURG, WATERLOO, IA

ROSE MIDDLETON, BOARD MEMBER, PEOPLES COMMUNITY HEALTH CLINIC, WATERLOO, IA

MARTHA NASH, BOARD MEMBER, PEOPLES COMMUNITY HEALTH CLINIC, WATERLOO, IA

INTRODUCTION OF PANEL 3

Senator HARKIN. Thank you very much. Our third and final panel are people who use community health center services. Miss Pat Brandenburg is a Waterloo resident and mother who receives health care from Peoples Community Health. Just come on up here and just take a seat.

Ms. Rose Middleton is a user of the Peoples Community Health Clinic and a founding board member of the clinic. Community health centers are required by law to have a board that is made up of community members and clinic users.

Ms. Martha Nash is a board member of Peoples Clinic and a clinic user.

STATEMENT OF PATRICIA BRANDENBURG

Fifteen minutes left. That is why I keep getting these notes coming up all the time. So welcome to the subcommittee; and again, I appreciate it. I had one letter that I read on the way up that was really good. Pat Brandenburg.

Ms. BRANDENBURG. Thank you.

Senator HARKIN. It was very good.

Ms. BRANDENBURG. Thank you.

Senator HARKIN. I enjoyed that a lot. It was a very good letter; and if you could, just sort of kind of summarize it and tell us what you think we ought to know when we walk out of here. All right we will start with you.

Ms. BRANDENBURG. OK. Thank you. I am the mother of nine children. All my children are special to me, but six of my children are designated special-needs children. Any doctor taking care of my family has to know more than how to cure a diaper rash or handle a sniffle.

If you walk into my home, you are going to find three IV poles. Connected to three IV poles you will find a feeding pump. Follow the tubing, and you will find two little girls and a little boy. Look around the house, and you will find oxygen concentrators, suction machines, braces, wheelchairs, and beds to fit the needs of each of my children.

You will also find an empty bed and next to it life support equipment that is silent, a reminder of our 5-year-old, who died only a few weeks ago.

When I was looking for health care for my children, what did I need? First I needed a place that would take title 19. It was a shock to me to discover a lot of doctors in the area will not, and they tell you so in a not-so-fine fashion.

It was also a shock to me to discover that my husband's—one-third of my husband's income was being used for insurance that only covered three members of our family and does not really cover us that well. Everything else is title 19, and here Peoples Clinic has helped us out immensely.

I needed people who would not give up on my children, and I needed people who would treat them as human beings. Not all people treat profoundly retarded or underdeveloped children with care. But here at Peoples Clinic, we are treated in wonderful ways.

It will be hard for me to forget the day that Dr. Gordon called us into the office with Trev. She told us that Trev did not have much longer to live. She also told us that they would be here by our side to help us give Trev the best peaceful, comfortable death possible.

They suggested we put Trevor on the Hospice rolls. We did. We took him home to die, and Peoples Clinic was here only a phone call away. And yes, they made house calls; and they still do, to help us with our other children, some of whom are also terminal.

One of Peoples Clinic's greatest assets is Barb Erickson. Barb is the special needs coordinator for Peoples Clinic. She is the person

that helps get us what we need when we need it and where we need it from.

Right now one of the projects Barb is working on is to get title 19 to pay for formula for our 3-, 5-, and 6-year-old. Their only life feeding is formula. Last month we put out about $500 in formula. I do not understand why I have to fight for things that are supposed to be ours already; and at the same time, I see some of these same agencies misusing their title 19 dollars.

Yes; we do need help from clinics like this. We need more clinics exactly like this one. We need your help in funding them, and we need your help in providing appropriate care. It is not just medicine that they dish out here, but they also give us loving care.

PREPARED STATEMENT

We have just figured out that $133 a month I am spending on diabetic supplies, 4 by 4 squares to go under Trevor's trach and used around his feeding tube for $1.50 apiece. We would go through anywhere from three to a dozen of those a day. Some of these things I think you need to look into. The costs are just outlandish.

We thank you for what you have done so far and thank you for letting me say these things.

Senator HARKIN. I cannot say it much better than what you just said it.

[The statement follows:]

STATEMENT OF PATRICIA BRANDENBURG

I am Patricia Brandenburg, mother of nine. While all my children are very special to me, six are special needs. Any doctor taking care of the Brandenburg clan needs to know more than how to cure diaper rash or handle a case of the sniffles.

If you walked into my home you would see three IV poles, attached to each is a feeding pump. Follow the tubing you would see two beautiful little girls and one adorable little boy. You would see two monitors and if you stayed around you would hear those monitors beep off warning us of possible danger. You would see oxygen tanks and an oxygen consentrator, wheelchairs, braces, and beds fitted for each childs needs.

In one room you will find an empty bed and life support equipment now quiet, a silent reminder of a wonderful 5-year-old boy; who died only a few weeks ago.

When looking for health care for my children, what did I need? First, I needed a place that took title 19 and had a sliding rate for my family that was under insured. I found that not every doctors office wanted to take title 19 and some of them were not so nice about telling me so.

When it comes to other insurance what a shock to realize that almost one-third of my husbands pay is going for insurance and we are still under insured. High cost of insurance and poor coverage is something you need to look into.

I needed people who wouldn't give up on the kids and who treated each of them as human beings. Not only do we need people who can dispense medicine, but just as important we need people who care. Peoples Community Health Clinic have been caring for us in wonderful ways.

I will never forget the day in December we brought Trevor down to the clinic. My husband and I sensed the news would not be good. Dr. Gorden and Barb Ericksen came in. Dr. Gordon told us that Trevor would not live much longer. They assured us they would be here for Trevor and for us. They would help us help Trevor to die as peacefully and comfortably as possible. Trevor was put on the Hospice roll and allowed to die at home. The people from the clinic and Hospice were never more than a phone call away, and yes, they made house calls, they still do to help with my other children, some who are also terminal.

One of Peoples greatest assets is Barb Ericksen. Barb is the special needs coordinator for the clinic. She helps us get what we need from where ever we need to get it. One of the things Barb is working on for us is getting title 19 to pay for formula for our 3-year-old, 5-year-old, and our 6-year-old. They live only on formula. Last

month we paid about $500 for formula. Why must we fight to get what we our told is there for us?

Listen well Congress, we need more clinics like this one. We need your money and we need your help in finding appropriate staff. We don't need to fight for affordable care and services when we are faced with long-term and life-threatening problems. Thank you.

STATEMENT OF ROSE MIDDLETON

Senator HARKIN. And next would be Miss Rose Middleton.

Ms. MIDDLETON. I led a very sheltered life. I am from a large family. My father worked at John Deere, and he managed to provide for his family, at a considerable cost to him, the health care that I personally think is the right of every child born in this country and in this world.

He did not do that easily. At the time that he was working there, we were small. It cost him a great deal. He worked two, and sometimes three, jobs in order to provide health care that some of us needed. Some of us were very healthy, some of us had special needs; but he managed to do it anyway. We always enjoyed a relationship with a family doctor, an ongoing relationship.

And as I said, I led a sheltered life, because during the 10 years that I was married and lived in Minnesota, western Iowa, northeastern Iowa, southern Iowa, all over the State, I was always accessible to my family doctor here and continued that relationship.

However, after my divorce and sitting on a couple of boards, I found out that not everybody was as lucky as I was; that there were people who were being turned down when they called for an appointment to have their child checked because they had a fever, they were ill, and were told to go to the emergency room.

By this time I was working at Deere's, and so I had health insurance; and when my doctor retired and I went to look for another doctor, I did not have a lot of difficulty.

However, as I say, going on and on and on, in 1975 I was asked by a social worker at the day-care center where my kids go if I would like to serve on a committee; and they were in the process of trying to find doctors and health care for a number of the less fortunate children at the day-care center.

We did a survey calling for appointments; and I would like to tell you, 3 years ago, when my physician retired, I called again to find doctors, and the situation evidently has not changed. People were turned—the first thing I was asked was did I have insurance, what kind of insurance, if I had any other source of income, who else would be responsible for my bills, and a number of other questions. In the course of a 7-minute conversation, I was never asked my name.

And I was told that it would be 3 months before I could get in to see this doctor, that that was the soonest they could get me in because I was a new patient. And even though I told them I had an immediate problem that needed to be taken care of that had been going on for several weeks, that was still their response.

So unfortunately I was very saddened to learn this, because even though I had the resources, I was not able to get in. So I know that people who are uninsured and underinsured are having an even greater difficulty than I am.

At the same time you have the hospitals—they have problems with people using emergency rooms as their primary health care. This is an acute problem on both sides, because the patient who has to resort to that does not ever become a full partner in their health care. They do not learn how to take care of themselves. They do not learn how to practice preventive health care. They are receiving very expensive health care that is for the moment. The follow-up is not there.

The one thing that Peoples Clinic does, and the one thing that we, as original board members, wanted to make sure happened was that people became healthier and that they led healthy productive lives; and in order to do this, you need to first of all get them into the mode that they use a primary care physician.

And I was very gratified that the Federal Government, when they came in and gave us our first grant, had no problems with the idea—the concept that because you were poor and could not pay for all of your health care did not mean that you did not deserve the best health care that was available. At Peoples Clinic, that was our philosophy and our goal, was to provide the very best health care to whoever needed it.

There are a number of things that I could say. I know that your time is limited, but I would like to write something and give it to you. This gives you an idea of what—how this started, and it is still fulfilling its original purpose and goals.

Senator HARKIN. Thank you. I appreciate that. If you want to write up something, we will leave the record open to take any letter or information that you want to send us.

STATEMENT OF MARTHA NASH

And next, Martha Nash.

Ms. NASH. OK. As I said, I am a patient and a board member of the Peoples Community Health Center, and it feels like I have been there forever.

Senator HARKIN. Well, you get a good member, and you just——

Ms. NASH. I was involved not as a board member, but in the creation of this and in the first grant because my personal exposure to health care has been long and early, particularly in dealing with the African-American community in Waterloo.

My father was a doctor, and my husband was a doctor in Waterloo; and both—because my husband's health deteriorated, I really began to wonder who was going to take care of people, because he saw a lot of the people who were title 19. And in fact, I guess if you go back and look at the records of March 1979 you will see an article in the Waterloo Courier following his death speculating on who was going to take care of some of the low income now that he had died.

I also was involved very extensively in the health care planning system, first with the old community health system groups, or the B agencies, as they called them, then when they created the health systems agencies, which I am very sorry that Congress sought to kill, because I think we were really getting somewhere with those in developing health planning and developing resources where they should go.

And also I served for a while with the State health department Health Facilities Committee to review and comment on health facilities. So I have learned not only from being—in that way and being a consumer of health care, relative of providers of health care—and I still have a brother-in-law in Cedar Rapids who is a physician also—but also in the health clinic since.

Health centers, to me, and the issue that I was always concerned about in health care was about access. Real access for people. It is fine to say that you have got places located here and there, but financial and where they are located will determine whether somebody really has that or not.

I hear you talking about hospitals in Iowa, and I am wondering what the people in Postville are going to say about whether they are close to a hospital when they close it. And we may have a few more rural Iowa closings because of financial considerations.

Also, I know in southwest Iowa it is not easy. It may sound in miles like it is not too far. It may not be easy by road to get there. If you do not have transportation, it is not accessible; and if you do not have the money, it may not be accessible, no matter where they are located.

So those are a lot of things that I felt that community health centers could help answer, the issue of being very accessible for people who are either limited income, have no income, or have no health insurance.

We do know that the availability of grant dollars and primary care physicians prevent community health centers from serving the number of people that really need their services who have a limited income and limited resources; and it should be obvious to everyone here that the issue of access to primary care in Waterloo, as well as other communities in the State, as well as in the Midwest and in the United States, should be the focus of more and more of our concern.

In Waterloo itself, I think the health care providers are beginning to realize that the problem of access to health care is not just a problem of the Peoples Community Health Clinics, but is also a problem of the community; and it is not just something a Federal program can solve, but it is a community problem to resolve. Hospital boards and administrators now understand that the capacity of a community health center to serve the population in need impacts on their operation; and I hope that this is true—really true; that the local medical society no longer views the center as a benign program with limited importance to the community or as a competitor for patients, which some of them get worried about.

More and more private practice physicians have begun to try and assist the clinic with its physician capacity, and the local family practice residency training program continues to evaluate how it can carry out its mission of physician training while helping support the physician capacity of Peoples Clinic. These positive changes have occurred, in part, because of the capacity limitations our center continues to encounter; and the phase-down of the National Health Service Corps has been a major barrier to both the clinic and most other community health centers in its ability to serve the needy population.

This problem does have a positive sign, however. It has forced many community health centers to develop a much more positive environment for physicians to work in; and this must continue.

However, I would recommend that Congress recognize that the task for recruitment and retention is going to take multiple approaches. People have found it hard to recruit primary care physicians to the Midwest, hard to recruit them to Iowa, and even harder to recruit them to Waterloo, and even harder to recruit them to the community health center located in Waterloo.

I would recommend that Congress consider the following:

To continue the expansion of the scholarship program of the National Health Service Corps;

Expand the Federal and State match physician loan program;

Provide tax credits for physicians practicing in special populations who have limited access to health care—we give tax breaks to everybody else, so why not to them;

And also that Congress realize that the current funding of community health centers is only reaching a portion of the population in need for access to health care—and as you have heard today, that population seems to be expanding, rather than contracting;

Also consider expanding the funding at existing centers, initiating new centers, and developing satellites. I could see this center providing satellite programs in various places in our area.

As indicated before, my comments are based on many years of exposure to the serious and growing problems of access to health care right here in our Midwest. We have serious problems with regard to access; and all community health care providers, both public and private, have to have ownership of the problem.

I also believe that Congress must expand the capacity of our community health centers for a community to really accomplish any long-term service delivery area through this population. And may I say, while it is fine for the University of Iowa to go out and approach people for the department of health, you have got to find a viable group in the community that really wants to develop a community health center, and sometimes you have to develop that before you can really begin to develop the community health centers.

Greed has got to fill the need, because I have got a real question, when he is identifying all those things, why not Cedar Rapids? That is where I am close to. Thank you. And I know Cedar Rapids, and so I am wondering why Cedar Rapids is—probably has as much need as the rest of us.

Senator HARKIN. I do not know the answer to the question. Thank you very much. I appreciate it. Tom, do you have any questions?

Senator DASCHLE. I have no questions, but I want to commend all of our witnesses. Sometimes you come up with the most remarkable testimony in places least expected. It happened to me in Fremont, NE, a couple of weeks ago, and certainly this afternoon with Mrs. Brandenburg; and some of the tales you must be able to tell. I am sure you abbreviated your testimony; but I commend you not only for your testimony, but for what you are trying to do. I thank all of our witnesses for their very articulate comments this afternoon.

Senator HARKIN. Thank you all very much. Time has prevented me from doing too much of this, but I always—I have sort of a stated policy at all of my hearings that I conduct, either in Washington or in the field, that at the end of the hearing I like to open it up to anyone in the audience who has a comment, question, an observation. And all you have to do is state your name for the hearing record, for our recorder here; and if you would like to make a statement or comment or observation, I would like to hear it. I cannot do too many, because we have got to leave here shortly; but if somebody does, just give me your name and state it for the record

STATEMENT OF DONALD CLENDENNEN

Mr. CLENDENNEN. My name is Donald Clendennen, C-l-e-n-d-e-n-n-e-n; and I wish that—Senator Moynihan from New York here a while back was talking about the Social Security surplus, some $52 billion in Social Security surplus, that he was going to roll it over, tax cut, or something; and I guess it is being used for the national deficit, if I am right.

Senator HARKIN. Yes.

Mr. CLENDENNEN. I was wondering why this surplus is not being used more on health care, why—that there are 37 million people without insurance; and it is a sad affair in a lot of cases.

Senator HARKIN. I am sure glad I have Senator Daschle along today to answer that question as a recognized expert in that area.

I am just kidding. You correctly stated there is a surplus in the Social Security trust fund, and it is being used to mask the deficit; and I think that is what Senator Moynihan is after, was to show that that is what is being done. It should be perhaps invested in more productive areas in our society. I would not have any more to say to that unless Tom does.

Senator DASCHLE. I would only say that I think Senator Moynihan points out a very valid criticism in the Social Security system as it exists right now. We ought to take it off budget, and we are going to be doing that. We ought to assure, for deficit reduction purposes, we do not use trust fund moneys for purposes other than what they were designated for; and I hope that in the next couple of years we can actually do that through legislation. I think there is a good deal of support for it.

Senator HARKIN. Back there?

STATEMENT OF DR. JOHN LALOR, NATIONAL SERVICE CORPS

Dr. LALOR. I am Dr. John Lalor. I am one of the National Service Corps people that will be completing their tour of duty here.

Senator HARKIN. This year?

Dr. LALOR. This year.

Senator HARKIN. And when did you start?

Dr. LALOR. 1986.

Senator HARKIN. So you have been here 4 years?

Dr. LALOR. Four years. I want to bring out and also stress to you a point that is not being brought out here and will definitely affect rural health care and also inner city health care, and that is the fact that there is going to need to be a great increase in funding for the training of physicians too.

I used to be on the board of directors of the State Family Practice Academy in New York; and we did an age distribution there, and one of the largest age groups of physicians is in the greater than 65 age range. And these physicians also provide a lot of the rural health care.

A lot of factors are causing these people to quit early; the Medicare problems, the funding, the inequities there; the overwork, especially with greater need for, you know, new techniques and keeping up, things like that; and plus they are just getting burned out after years of service.

But we need to replace those physicians. I know in New York we were not replacing the physicians that we were losing just by attrition, OK, and that is primary care physicians. So that is just going to eventually lead to, you know, further demands on the health care system, community health centers like we have here. I think there is going to need to be a lot more funding there.

I also think this whole problem has to be attacked in the education system too. From seeing my own quizzing of kids that come in through the schools, and things like that, a lot of them do not know simple things about health, and things like that. So I think more emphasis has to be placed on education, and a lot more dollars have to be placed in preventative medicine, rather than waiting until things happen.

I think that a lot of doctors are very upset for the fact that they cannot get immunizations paid for in their offices. People have to pay for it themselves. Things like that, which might prevent problems in the future. Right now they have to wait until someone has an acute illness in order to get paid. And there are a lot of other comments I would like to make in a letter.

Senator HARKIN. I have a bill which I have introduced with a lot of cosponsors—I know Senator Daschle's on it—Health Objectives Act of 2000, which hopefully will be passed sometime this summer. The President is anxious to get it and sign it. It codifies the findings of the Surgeon General as to the needs for the next decade. And the basic thrust of that is preventative care. It is taking moneys and putting it into just the things that you are talking about, into immunizations, education programs, the primary care, that type of thing, in the prevention area. One other—I am sorry. Go ahead.

Dr. LALOR. I have one other comment. We keep talking about the care of physicians, nurses, and things like that. Another thing that is a big problem in rural areas is support services; physical therapy, occupational therapy, people that—I have had several people, they go in with a broken hip, they do not get to come back home, they go into the nursing home because they cannot get physical therapy on outside services. They cannot get it paid for.

Again, the access is a huge problem in the rural area. Many people cannot get in to have a consult, you know, unless they end up by ambulance. Then you have all those problems again. Becomes an acute problem, not preventative.

STATEMENT OF WILL RODGERS, DIRECTOR, COMMUNITY HEALTH CARE CENTER

Mr. RODGERS. My name is Will Rodgers. I am the director of the Community Health Care Center in Davenport, IA. One of the things that is—both of the Senators were dumfounded by the multiple designation of shortage areas through MUA's and HMSA's. Oftentimes when we try to integrate the various federally funded programs, whether they come through the Federal or the State of Iowa, we are faced with multiple granting and multiple grant years, multiple reporting requirements, and everything else. And I think if there is some notion of having some kind of a single source application, that would make maternal and child health, family planning, you know, WIC funding possible and take away some of the multiple and overlapping reporting requirements would be very helpful.

Senator HARKIN. Single-source application. Good idea. Well, I am told I have got to cut it off. We have to go. Well, thank you again all for coming. This concludes today's hearing.

I want to thank the witnesses, members of the community that came out to explore the options for improving access to quality primary health care in Iowa. I join my colleague, Senator Daschle, in saying I was very impressed by all of the testimony.

The final decision about the need for additional community health centers will rest with community leaders and the several medically underserved areas in Iowa. If these communities come forward with applications, I intend to do my part as chairman of the Labor, Health and Human Services Appropriations Subcommittee to make sure they are funded.

All of those areas, National Health Service Corps, community health centers, the training programs for family doctors and nurses and allied health professionals, supporting programs like maternal and child health care programs all come under the subcommittee I chair. And all I can say is that—well, some of you heard me say it before, but less B-2 bombers, and more money for primary health care and community health centers and rural health care; and that really answers the real security needs of this country. And we are going to continue to do what we can to reorder those priorities.

[CLERK'S NOTE.—The following statement was received by the subcommittee subsequent to conclusion of the hearing. The statement will be inserted in the record at this point.]

STATEMENT OF RAYMOND BURFEIND

Peoples Community Health Clinic, Waterloo, IA, has provided 10 years of service as a community health center. I am pleased to offer Covenant Medical Center's comments in support of the mission, goals, and objectives of Peoples Community Health Clinic.

Covenant Medical Center recognizes and supports the successful efforts of Peoples Clinic to provide primary health care services to the thousands of persons who are either unable to or who prefer not to make use of the traditionally available physician services within the community. The services of Peoples Community Health Clinic are well integrated into the total health care resource network available to the Waterloo-Cedar Falls community.

Peoples Community Health Clinic has accepted the challenge of providing primary medical services for low income persons within our area. While segments of the health care delivery system accept this responsibility to one degree or another, with hospitals providing significant amounts of uncompensated care for needy indi-

viduals, it is difficult to provide primary medical care at a reduced cost within the framework of the private physician's office in an era of rising costs. Peoples Community Health Clinic continues to accept the responsibility of being complementary to, rather than duplicative of, other health care services, and has retained considerable support throughout the entire medical community.

Peoples Clinic also is recognized for providing appropriate care with dignity and without asking patients to rely on the relatively expensive emergency room service as an alternative to primary care.

Now, however, community health clinics generally, and Peoples Community Health Clinic in particular, are in need of support which will allow them to successfully recruit and retain physicians and other personnel. The United States Public Health Service Program which previously provided an option to physicians to serve in a community service capacity to offset their medical training costs has ended. A new mechanism for securing needed personnel must now be established. Your support for such action is encouraged and appreciated.

Again, I am pleased to offer this testimony in support of the very vital role which Peoples Community Health Clinic plays in the total health care network of our community.

CONCLUSION OF HEARING

Senator HARKIN. Thank you. This gives us good information for us to use as we move ahead into the next funding cycle. Thank you all for coming out, and the subcommittee will stand in recess subject to the call of the Chair.

[Whereupon, at 4:30 p.m., Saturday, June 16, the hearing was concluded, and the subcommittee was recessed, to reconvene subject to the call of the Chair.]

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